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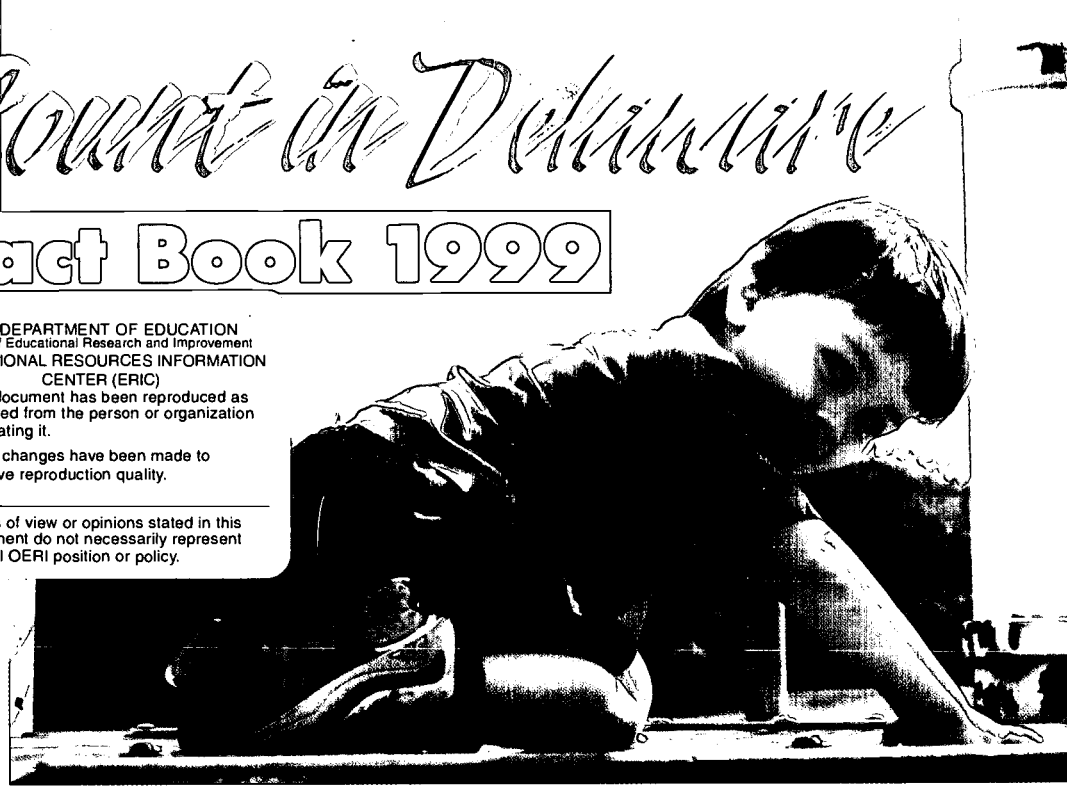
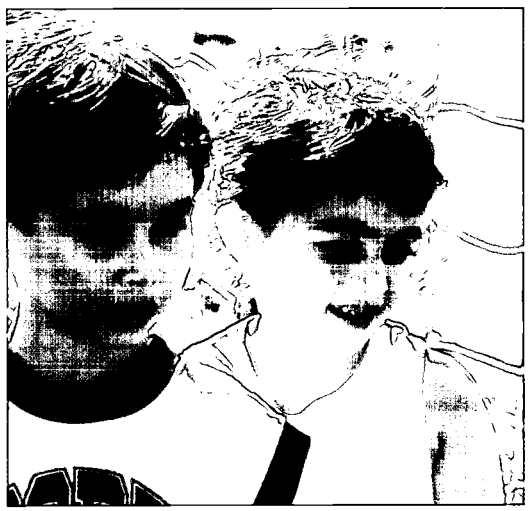
ABSTRACT

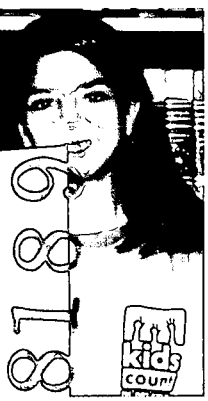
This Kids Count Fact Book is combined with the Families Count Fact Book to provide information on statewide trends affecting children and families in Delaware. The Kids Count statistical profile is based on 10 main indicators of child well-being: (1) births to teens; (2) low birth weight babies; (3) infant mortality; (4) child deaths; (5) teen deaths; (6) juvenile violent crime arrests; (7) high school dropouts; (8) teens not in school and not working; (9) children in poverty; and (10) children in one-parent households. Additional issues affecting children profiled in the report include: (1) early care and education; (2) children receiving free and reduced price school meals; (3) women and children receiving WIC; (4) asthma; (5) children without health insurance; (6) alcohol, tobacco, and other drugs; (7) child abuse and neglect and (8) foster care. The report indicates improvement or a better than national average in the teen birth rate and the juvenile violent crime arrest rate but notes increasing rates of low birth weight babies; teen deaths by accidents, homicide, and suicide; children living in poverty; children in one-parent households, and teens not graduated and not enrolled. The report includes 68 data tables related to the indicators. The Families Count statistical profile details the conditions of families, children, and individuals in Delaware communities. The five indicator categories are: (1) healthy children; (2) successful learners; (3) resourceful families; (4) nurturing families, and (5) strong and supportive communities. Comparisons of Delaware trends to national trends in these areas are included. (HTH)

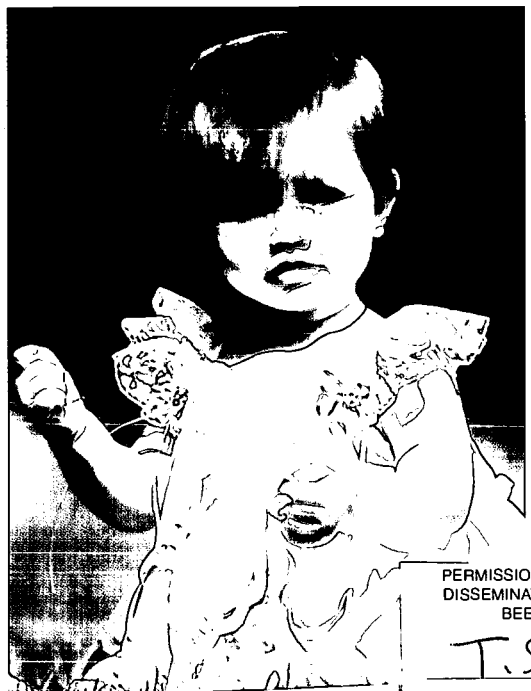
Kids Count in Delaware

Fact Book 1999









STATE OF DELAWARE
OFFICE OF THE GOVERNOR

THOMAS R. CARPER
GOVERNOR

Dear Friends:

Children are our most precious resource. They need strong, loving adults who are willing to take care of their needs and guide them through their formative years. They also need to believe that they matter—that their thoughts, opinions, feelings and life experiences count. This is why I believe in the KIDS COUNT Fact Book.

These pages are more than just facts and figures; they tell us a meaningful story of what it can be like to be a child in Delaware. They inform community members, decisions makers and the general public about the circumstances and needs of our children. For the more informed we are, the better decisions we make in building a brighter future for our children.

I hope you find this report helpful and informative in your continued efforts to spread the message "Families and Kids Count in Delaware!"

Sincerely,

Thomas R. Carper
Governor

Governor Carper with Milford High School teens who participated in the KIDS COUNT project "Kids Voices Count"

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Kids Count in Delaware

Fact Book 1999

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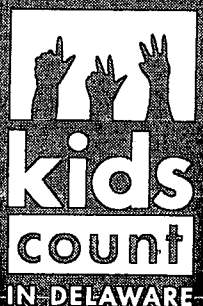

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The photographs in this book do not necessarily represent the situations described.

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Thanks to

Janice L. Sturgis
Center for Community Development and Family Policy University of Delaware

And a special thank you to the Delaware children featured on the cover and throughout this book.

Dedicated to all the people in Delaware who put kids first in everything they do.

A Message from Kids Count in Delaware

"The solutions for adult problems tomorrow depend in large measure upon the way our children grow up today. There is no greater insight into the future than recognizing when we save our children, we save ourselves."

– Margaret Mead

In this our fifth annual profile of Delaware's children, *KIDS COUNT in Delaware Fact Book 1999*, we look at some of the greatest challenges in the lives of our children and youth, aiming to create a holistic view of how children are faring in Delaware. Of course many of Delaware's children are born healthy, succeed in school, and become happy and productive adults. Most of Delaware's children are surviving but one in seven lives in poverty. We want more for our kids that just survival; we want them all to thrive, with a lifetime of happiness and prosperity. This fact book draws attention to the inequality that exists for our state's children, some of whom face seemingly insurmountable barriers to success.

KIDS COUNT in Delaware is one of fifty-one similar projects throughout the United States funded by the Annie E. Casey Foundation. Through this project housed at the Center for Community Development and Family Policy at the University of Delaware, led by a Steering Committee of committed and concerned children's advocates from the public and private sector, we bring together the best available data to measure the health, economic, educational and social well-being of children. This publication represents our ongoing effort to paint a picture, which will inform public policy and spur community action.

This edition is combined with the initiative of Governor Carper's Family Services Cabinet Council entitled *FAMILIES COUNT in Delaware* which expands upon the ten tracking indicators of the *National KIDS COUNT Data Book* to look at a broad range of indicators related to families in Delaware. For the second year, we are pleased to present to you both KIDS COUNT and FAMILIES COUNT as a combined publication and believe that it represents a statewide commitment to monitor outcomes and show that both children and families do matter, do count, in this state.

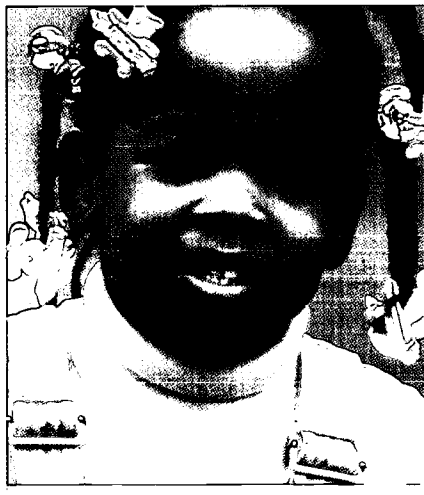
At KIDS COUNT, we do not want you to think of this publication as just a report, but rather as a tool to guide, direct and motivate policy leaders, advocates and the public to do what they can to improve the quality of life for Delaware's children. This could mean volunteering as a mentor for a disadvantaged youth, creating a child care center in the workplace, or passing legislation to enable all children living in poverty to attend Head Start programs. It means working with our friends, relatives and co-workers to ensure that elected officials make tax and spending choices that will help children succeed. It means becoming actively involved in building a stronger Delaware, one step at a time.

Do your part to make KIDS COUNT and FAMILIES COUNT in Delaware!

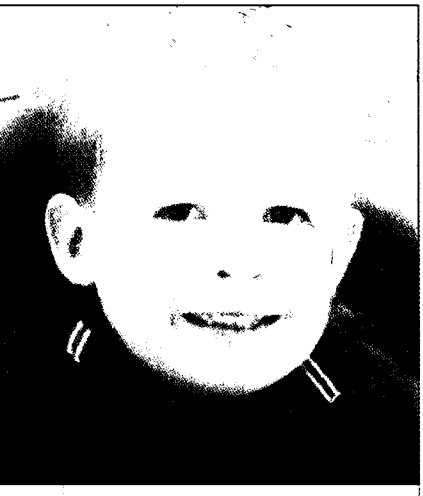
Nancy Wilson, Ph.D.
Chair
Steering Committee

Steven A. Dowshen, M.D.
Chair
Data Committee

Table of Contents



Data Tables



Demographics

Births to Teens

Low Birth Weight Babies

Infant Mortality

Child Deaths

Teen Deaths

Juvenile Violent Crime

School Dropouts

Teens Not in School and Not in the Labor Force

Children in Poverty

Children in One-Parent Families

Miscellaneous Tables

Kids Count in Delaware

Take a look at the faces in the photographs throughout this book. They're as varied as the influences on each of their lives, and that's why the *KIDS COUNT in Delaware Fact Book 1999* gives you a broad spectrum of indicators that lend a balanced perspective for considering a child's well-being. In addition to the ten indicators used by the Annie E. Casey Foundation's *KIDS COUNT National Data Book*, we continue to report on early care and education, alcohol, drug and tobacco use, women and children receiving WIC, free and reduced-priced school meals and asthma data based on hospitalizations. Several areas have been expanded with Impact Statements and sources for further information. Both the appendix of tables and the FAMILIES COUNT section contain supporting documentation for many of the graphs in the KIDS COUNT section.

The ten featured indicators in this book have been chosen by the national KIDS COUNT project because they provide a picture of the actual condition of children rather than a summary of programs delivered or funds expended on behalf of children. These indicators have three attributes:

- They reflect a broad range of influences affecting the well-being of children.
- They describe experiences across developmental stages from birth through early adulthood.
- They are consistent across states and over time, permitting legitimate comparisons.

The featured indicators are:

Births to teens

Low birth weight babies

Infant mortality

Child deaths

Teen deaths by accident, homicide, and suicide

Juvenile violent crime arrests

Teens not graduated and not enrolled

Teens not in school and not working

Children in poverty

Children in one-parent households

Trends in Delaware

Delaware has seen improvement in two of the national KIDS COUNT indicators while five of the indicators have declined and three have shown little change:

- ***The teen birth rate has improved for the first time since 1982.***
- ***The juvenile violent crime arrest rate has begun to decrease.***
- ***Of concern are the increasing rates of low birth weight babies, teen deaths by accident, homicide and suicide, children in poverty, children in one-parent households, and teens not graduated and not enrolled.***
- ***The rates of infant mortality, child deaths, and teens not attending school or working have shown little change over the past year.***

Making Sense of the Numbers

The information on each indicator is organized as follows:

- Definition — a description of the indicator and what it means
- Impact — the relationship of the indicator to child and family well-being
- Related information — material in the appendix or in FAMILIES COUNT relating to the indicators

Sources of Data

The data are presented primarily in three ways:

- Annual data for 1997
- Three-year and five-year averages through 1997 to minimize fluctuations of single-year data and provide more realistic pictures of children's outcomes
- Annual, three-year or five-year average data for a decade or longer to illustrate trends and permit long-term comparisons

The data has been gathered primarily from:

- The Center for Applied Demography and Survey Research, University of Delaware
- Delaware Health Statistics Center, Delaware Health and Social Services
- Department of Education, State of Delaware
- Delaware State Data Center, Delaware Economic Development Office
- Statistical Analysis Center, Executive Department, State of Delaware
- Delaware Health and Social Services, State of Delaware
- Department of Services for Children, Youth and Their Families, State of Delaware
- U.S. Bureau of the Census
- National Center for Health Statistics, U.S. Department of Health and Human Services
- Delaware Population Consortium
- Family and Workplace Connection
- Division of State Police, Department of Public Safety
- Domestic Violence Coordinating Council
- Center for Alcohol and Drug Studies, University of Delaware

Interpreting the Data

The KIDS COUNT Fact Book 1999 uses the most current, reliable data available. Where data was inadequate or unavailable, NA was used. For some data, only the decennial census has information at the county level.

Most indicators are presented as three- or five- year averages because rates based on small numbers of events in this state which has a relatively modest population can vary dramatically from year to year. A three- or five- year average is less susceptible to distortion. It is helpful to look at trends rather than at actual numbers, rates, or percentages due to the small numbers.

Accepted names for various racial and ethnic groups are constantly in flux and indicators differ in their terminology. KIDS COUNT has used the terminology reported by the data collection sources.

Fiscal Year Data: Most data presented here is for calendar years. Where data collected by state or federal authorities is available by school calendar year or fiscal year, the periods are from September to June or July 1 to June 30.

Notes: When necessary we have included technical or explanatory notes under the graphs or tables.

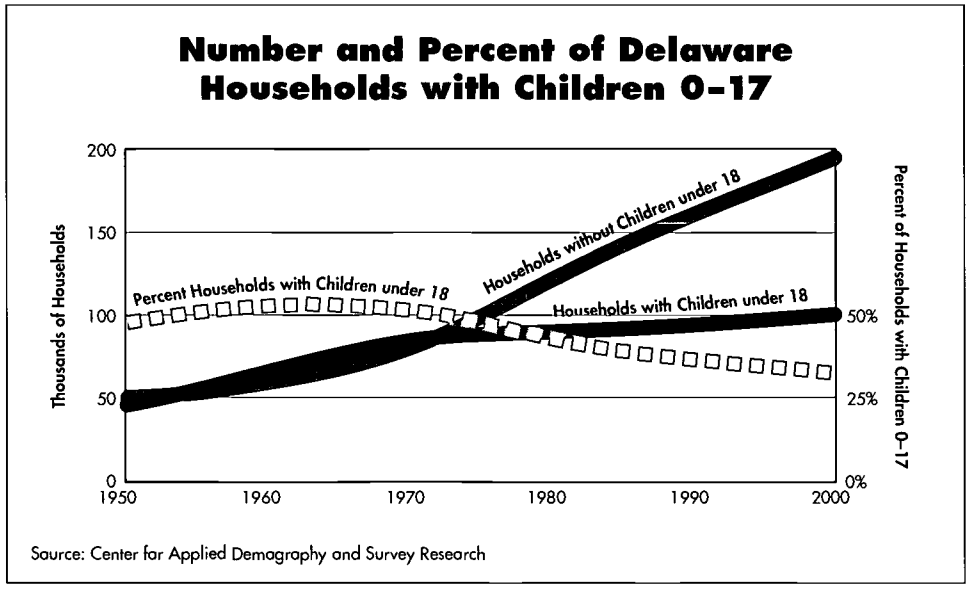
Counties and Cities: Where possible, data was delineated by counties and the city of Wilmington.

Pages are identified as KIDS COUNT (K) or FAMILIES COUNT (F).

As we quickly approach the year 2000, information from the 1990 U.S. Census becomes less reliable. However, it is helpful to provide this information to track trends.

One of the problems of providing accurate data is the lack of up-to-date information. For example, the source of child poverty facts in the United States is the U.S. Census Bureau. Census data are measured in two ways: once a decade (decennial) and by the Current Population Survey. Therefore, detailed information on child poverty can sometimes be unreliable due to age.

In a state with a small population such as Delaware, the standard sampling error is somewhat larger than in most states. For this reason, KIDS COUNT has portrayed the high school dropout rate in two ways: the sampling size, which shows trends, and the Department of Education's dropout numbers. There is a slight variation in those two graphs due to the size of the population.



Since 1950 the percent of households with children under the age of 18 has dropped dramatically. By 2000 almost 200,000 households in Delaware will have no children under 18, while children will reside in about 100,000 households.

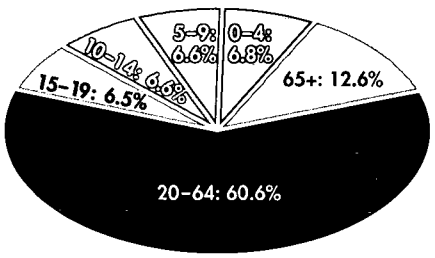
Numbers, Rates, and Percentages

Each statistic tells us something different about children. The numbers represent real individuals. The rates and percentages also represent real individuals but have the advantage of allowing for comparisons between the United States and Delaware and between counties.

In this publication, indicators are presented as either raw numbers (25), percentages (25%), or rates (25 per 1,000 or 25 per 100,000). The formula for percents or rates is the number of events divided by the population at risk of the event (county, state, U.S.) and multiplied by 100 for percent or 1,000 or 100,000 for rates.

Caution should be exercised when attempting to draw conclusions from percentages or rates which are based on small numbers. Delaware and its counties can show very large or very small percentages as a result of only a few events. KIDS COUNT encourages you to look at overall trends.

Population Estimate and Age Distribution
Delaware, 1997



Delaware Total	731,210
Total Children 0–19	201,102
Children 0–4	51,453
Children 5–9	50,203
Children 10–14	50,040
Children 15–19	49,406

Source: Population Estimates Program, Population Division, U.S. Census Bureau

K-11

A Caution About Drawing Conclusions

The key in the evaluation of statistics is to examine everything in context. The data challenges stereotypes, pushing us to look beyond the surface for the less obvious reasons for the numbers. Individual indicators, like the rest of life's concerns, do not exist in a vacuum and cannot be reduced to a set of the best and worst counties in our state.

Where county level data are presented, readers can gain a better understanding of the needs in particular segments of the state. Delaware rankings within the National KIDS COUNT Data Book can fluctuate from year to year. Therefore, it is important to look at the trends within the state and over a significant period of time. Hopefully the graphs help to clarify that picture.

Using the Fact Book

Data are a powerful springboard for asking the right questions.
This book is meant to be more than a mere collection of numbers. The data provided here can be used positively—as an advocacy tool to inform action. While numbers rarely can describe the entire story, they can be used to discern distinctive patterns in a county or state. Data do not necessarily provide answers. Mostly, they are a powerful springboard for asking the right questions. If your county varies greatly from the state norm, it should stimulate you to investigate the situation. Talk with experts in the field to find out what could explain the differences. Maybe the success from one area could be duplicated in another.

The Fact Book should help you gain a holistic perspective.
Even if you are not a child-related professional or a decision-maker, the data in this book should help you gain a holistic perspective. Take, for example, the divorce rate. It has increased over the past 25 years. As a result we see more children growing up in single-parent households than ever before. Most of these single parents are single mothers. In spite of the fact that many of these mothers are employed, many are still living in poverty. This has very serious policy implications as well as significant impacts on child well-being.

Negative statistics are red flags about children experiencing pain and diminished futures. As a reader and user of this book, we hope you will remember the limitations of the data contained here. Data do not have personality or emotions, but the people they represent do. These numbers encompass infants, toddlers, young adolescents, youth and families. Negative statistics are red flags about children experiencing pain and diminished futures. Positive data reflect that many Delaware youth have enjoyed a childhood that should lead to a better future.

There are limitations to the data.
Some indicators are composite indicators that lump diverse realities together. Infants can die from various causes such as birth defects, illnesses, accidents, and severe abuse—all of which have different policy implications and require different actions. So, while an indicator such as infant mortality does give us the facts, it does not tell the complete story. We must look at all aspects of the problem to arrive at solutions.

It is essential to understand what data are missing and what truths are lost.
We have taken great effort to acquire information to paint an accurate portrait of our children. However, many of these data are not available. We know our readers are interested in things such as how many children are waiting to be adopted, the number of youth who volunteered for community service, who regularly wore seat belts. Future publications may report such data.

We also know one must ask the right question in order to get the right information. When we ask how many youth were arrested for violent crimes, the answer will be a number. However, if we also choose to ask why and how these children become offenders, we could also get answers to more relevant issues. What could we have done—as parents, educators, clergy or lawmakers—to prevent such crimes? This is the kind of information needed to make truly informed policy decisions about children and youth.

Data should also highlight the good work being done across Delaware to help the next generation to succeed. Although there has been a proliferation of information about negative indicators and outcomes, much good is also happening for and accomplished by the youth in our state. We need to begin collecting more positive data about our children because many young Delawareans are being raised well and are making the right decisions.

The control over the use of these data becomes your responsibility.
As this document passes from our hands to yours, the use of these data becomes your responsibility. Like any other powerful tool, the data presented here have the potential to do harm as well as good. The inescapable moral obligation all of us have as adults is to use these data to the ultimate benefit of young Delawareans.

Note: Thanks to the *North Carolina Data Guide to Child Well-Being*, North Carolina Child Advocacy Institute for their insights into using the data.

20 Ways to Make Kids Count

There are many ways to make KIDS COUNT. The following are 20 ways to get you started:

1. **Listen to a child**
2. **Show interest in your child's education**
3. **Register and vote**
4. **Contribute financially to children's programs in your community**
5. **Volunteer at schools or children's programs in your community**
6. **Eat meals as a family**
7. **Be a mentor to an at-risk teen**
8. **Praise a child**
9. **Write a letter to a legislator on a children's issue**
10. **Educate yourself about the needs of children of all races and backgrounds**
11. **Teach children nonviolent ways to resolve conflict**
12. **Donate baby-care items and children's clothing to a foster care agency**
13. **Become a foster parent**
14. **Read a book to a child**
15. **Thank a teacher**
16. **Educate your children about their sexuality**
17. **Thank the media when they focus on children's issues in your community**
18. **Encourage your employer to sponsor a youth sports team or donate to a children's organization**
19. **Promote youth leadership**
20. **Use this book to identify problems and mobilize citizens**

Overview

	Delaware Compared to U.S. Average	Recent Trend in Delaware

Births to Teens Page 16

Number of births per 1,000 females ages 15–17

Five year average, 1993–97: Delaware 43.8, U.S. 35.5

Low Birth Weight Babies Page 20

Percentage of infants weighing less than 2,500 grams (5.5 lbs.) at live birth (includes very low birth weight)

Five year average, 1993–97: Delaware 8.2, U.S. 7.3

Infant Mortality Page 22

Number of deaths occurring in the first year of life per 1,000 live births

Five year average, 1993–97: Delaware 7.8, U.S. 7.7

Child Deaths Page 24

Number of deaths per 100,000 children 1–14 years old

Five year average, 1993–97: Delaware 23.5
Five year average, 1992–96: U.S. 28.3*

* U.S. data for 1993–97 was not available. 1992–96 data was used for comparison.

Teen Deaths by Accident, Homicide, and Suicide Page 26

Number of deaths per 100,000 teenagers 15–19 years old

Five year average, 1993–97: Delaware 51.1
Five year average, 1992–96: U.S. 66.1*

* U.S. data for 1993–97 was not available. 1992–96 data was used for comparison.

Delaware Compared to U.S. Average | Recent Trend in Delaware

Juvenile Violent Crime Arrest Rate Page 28

Number of arrests for violent crimes per 1,000 children 10–17; includes homicide, forcible rape, robbery, and aggravated assault

1997: Delaware 8.2, 1996*: U.S. 4.7

* U.S. data for 1997 was not available. 1996 data was used for comparison.

DELAWARE COMPARED TO U.S. AVERAGE: WORSE

RECENT TREND IN DELAWARE: GETTING BETTER

Teens Not Graduated and Not Enrolled Page 30

Percentage of youths 16–19 who are not in school and not high school graduates

Three year average, 1996–98: Delaware 12.0, U.S. 9.5

DELAWARE COMPARED TO U.S. AVERAGE: WORSE

RECENT TREND IN DELAWARE: GETTING WORSE

Teens Not Attending School and Not Working Page 32

Percentage of teenagers 16–19 who are not in school and not employed

Three year average, 1996–98: Delaware 7.1, U.S. 8.6

DELAWARE COMPARED TO U.S. AVERAGE: BETTER

RECENT TREND IN DELAWARE: ABOUT THE SAME

Children in Poverty Page 34

Percentage of children in poverty. In 1997 the poverty threshold for a one-parent, two-child family was $13,133. For a family of four with two children, the threshold was $16,530.

Three year average, 1996–98: Delaware 21.0, U.S. 16.0

DELAWARE COMPARED TO U.S. AVERAGE: BETTER

RECENT TREND IN DELAWARE: GETTING WORSE

Children in One-Parent Households Page 36

Percentage of children ages 0–17 living with one parent.

Three year average, 1996–98: Delaware 38.3, U.S. 30.8

DELAWARE COMPARED TO U.S. AVERAGE: WORSE

RECENT TREND IN DELAWARE: GETTING WORSE

Births to Teens 15-17

Birth Rate– number of births per 1,000 females in the same group

When teens have children, both mothers and babies suffer negative consequences. Teen mothers often lack the appropriate parenting skills and find it difficult to cope with the stresses of parenthood, particularly if they lack support of either the fathers of their children or of their families[1].

Often, the demands of fulfilling a parental role interferes with the teen mother's opportunity for peer relationships as well as the opportunity to develop her own sense of self-identity, a crucial development process for many individuals during their adolescent years[2].

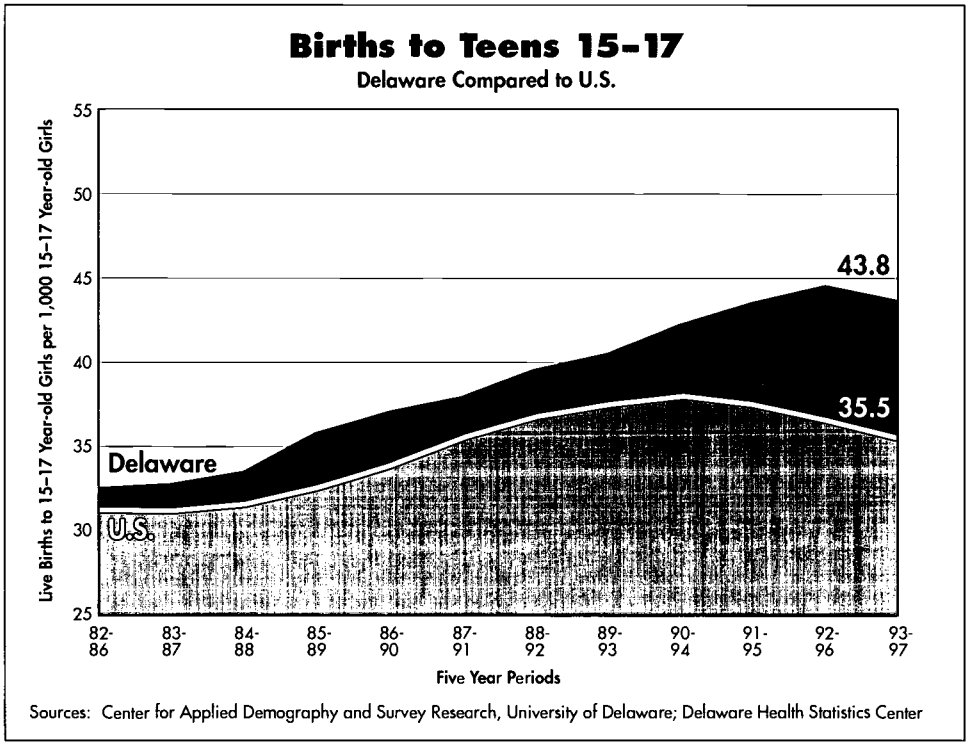
Infants born to teenage mothers tend to have lower birth weights and experience higher rates of premature delivery and infant mortality. As they grow older, these children are more likely to be injured or become ill, have academic and behavioral problems in school and become teenage parents themselves[3].

1 Births to Teens. (1998). Kentucky Kids Count, *1998 Data Book*

2 Births to Teens. (1999). Kansas Kids Count, *1999 Data Book*

3 Births to Teens. (1998). *Alabama Kids Count Report, 1999*

K-16



Sources: Center for Applied Demography and Survey Research, University of Delaware; Delaware Health Statistics Center

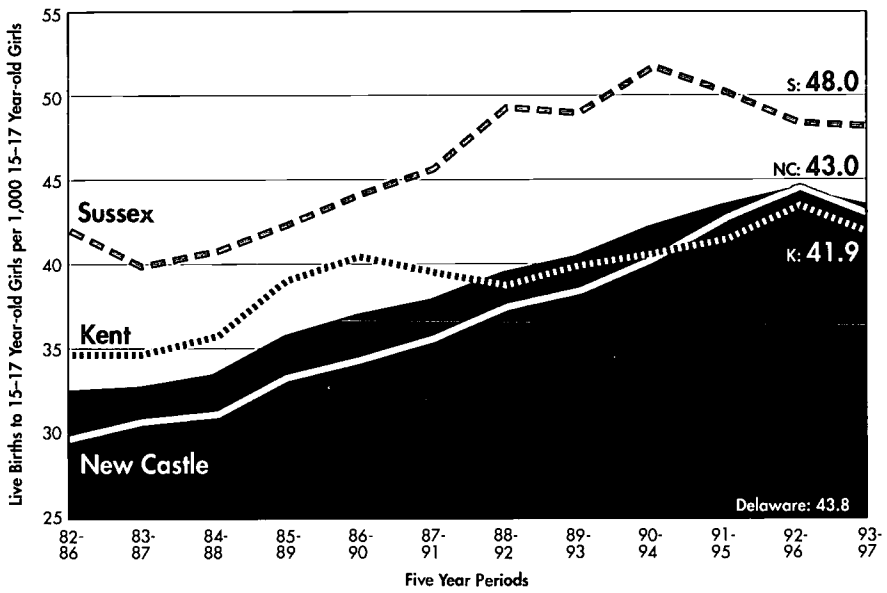
For the first time since the 1982-86 time period, the rate of births to teens ages 15-17 has dropped in Delaware.

Possible Solutions

Successful school-based teen pregnancy reduction programs target specific risk behaviors, personalize risk information, address social and media influences and provide practice in communication skills that help with refusal and negotiation. The goal is to delay onset of sexual activity and increase the use of contraceptives if sexual activity occurs.

Births to Teens 15–17

Delaware and Counties



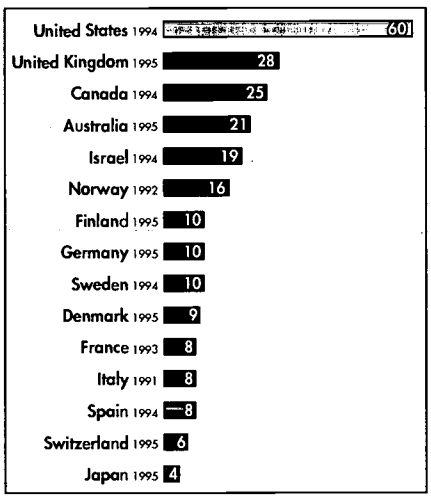
Sources: Center for Applied Demography and Survey Research, University of Delaware; Delaware Health Statistics Center

KIDS COUNT in Delaware | K-17

Did you know?

The United States has the highest teenage birth rate among developed countries.

Teen Birth Rates
for Selected Developed Countries
Rate per 1,000 females



Source: *United Nations, Demographic Yearbook: 1996* (New York, United Nations, 1998), pp. 353-364, Table 11.

Public costs from teenage childbearing totaled **$120 billion** from 1985–1990. **$48 billion** could have been saved if each birth had been postponed until the mother was at least 20 years old.

Source: Center for Disease Control and Prevention, www.cdc.gov

The sons of teen mothers are **13% more likely to end up in prison** while teen daughters are **22% more likely to become teen mothers** themselves.

Teenagers who have strong **emotional attachments to their parents** are much less likely to become sexually active at an early age.

Source: Teen Pregnancy Facts and Stats, www.teenpregnancy.org

For more information see

Birth to Teens 15-19	p. K-18
Birth to Unmarried Teens	p. K-19
Low Birth Weight by Age and Race of Mother	p. K-20
Infant Mortality by Age of Mother	p. K-23
Children in Poverty by Household Structure	p. K-34
Children in One-Parent Households	p. K-36
Tables 4-8	p. K-54-57
Tables 10-12	p. K-58-59
Tables 15-17	p. K-61-63

In the FAMILIES COUNT Section:

Teen Births	p. F-36
Sexually Transmitted Diseases	p. F-22

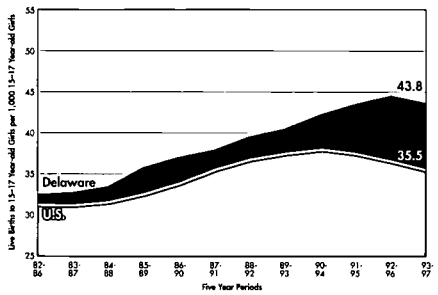
Births to Teens 15-19

K-18

While the birth rate for Delaware girls 15-17 has dropped slightly in Delaware, the rates for both age groups, girls 15-17 and girls 15-19, are above the national average.

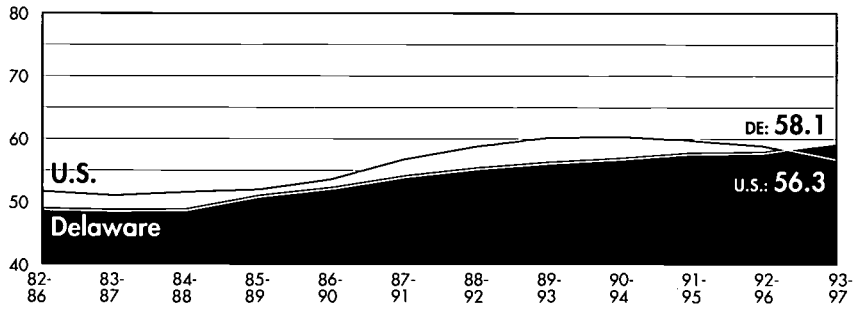
Births to Teens 15-17

as shown on page K-12



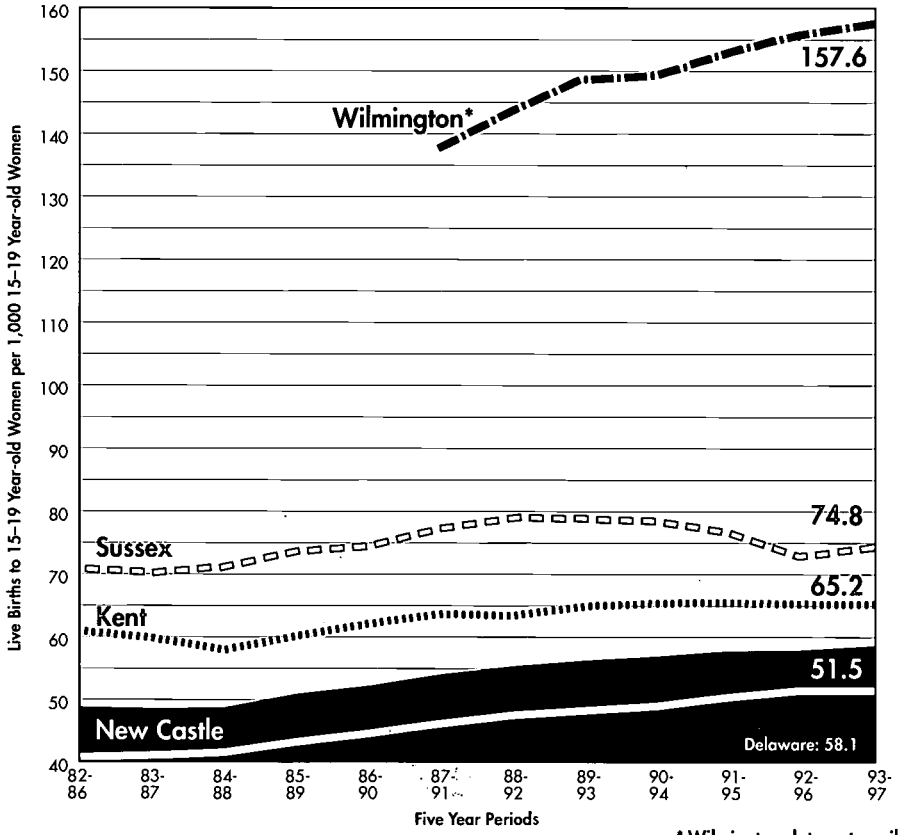
Births to Teens 15-19

Delaware Compared to U.S.



Births to Teens 15-19

Delaware, Counties, and Wilmington

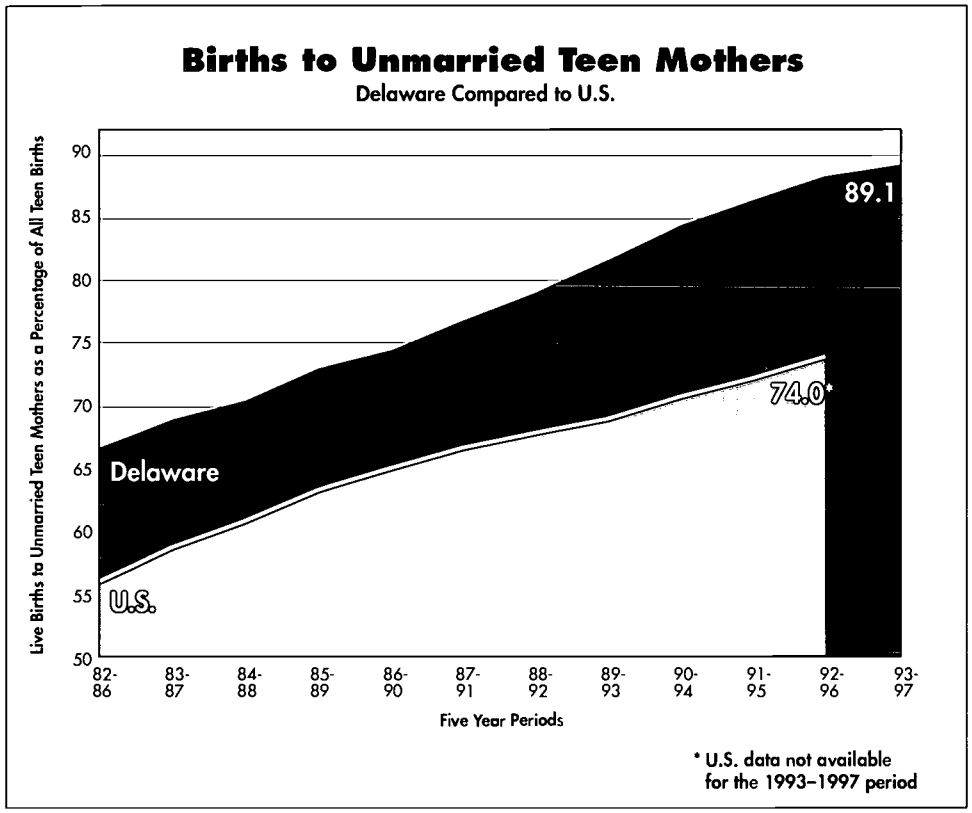


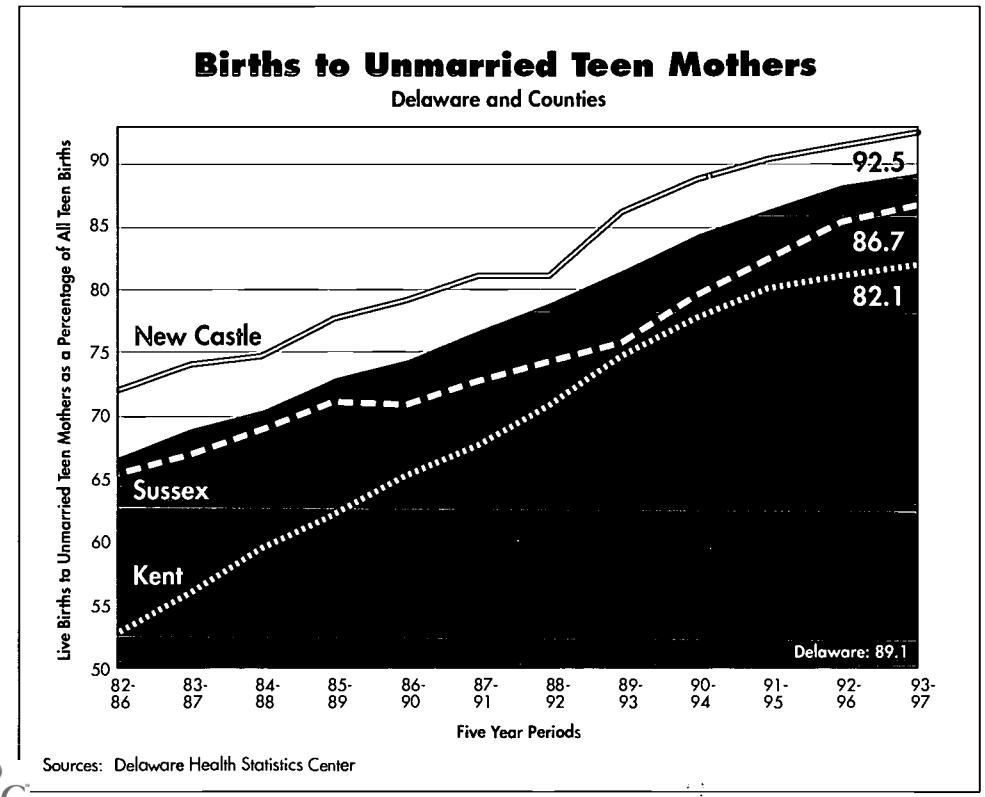
Sources: Delaware Health Statistics Center

* Wilmingtan data not available before the 1987-1991 period

Births to Unmarried Teens

The number of unmarried teen mothers giving birth in Delaware continues to grow, accounting for nearly 90% of all teen births.





Sources: Delaware Health Statistics Center

For more information see

Birth to Teens 15-17	p. K-16
Low Birth Weight by Age and Race of Mother	p. K-20
Infant Mortality by Age of Mother	p. K-23
Children in Poverty by Household Structure	p. K-34
Children in One-Parent Households	p. K-36
Tables 4-8	p. K-54-57
Tables 10-12	p. K-58-59
Tables 15-17	p. K-61-63

In the FAMILIES COUNT Section:

Teen Births	p. F-36
Sexually Transmitted Diseases	p. F-22

Low Birth Weight Babies

Low birth weight is defined as an infant being born at or below 2,500 grams (about 5.5 pounds). Babies weighing less than 5.5 pounds at birth are more likely to experience both physical and developmental problems than babies weighing more than 5.5 pounds at birth. Low birth weight babies may experience long-term physical problems such as an increased risk of adult-onset diabetes and coronary heart disease.[1] Developmental delays and problems causing the child to be placed in special education in school may also occur. At highest risk are babies weighing less than 3.3 pounds.[2] Risk factors associated with low birth weight include poor prenatal habits, in particular tobacco or alcohol use during pregnancy, low maternal weight gain, low maternal weight before pregnancy, and multiple births.[3] African-American women, teenage mothers, and mothers living in poverty are at a greater risk of experiencing low weight births. Despite being a small fraction of all births, low weight infants account for more than one-third of all dollars spent on health care for infants.[4]

1 Maianu, L. et al., 1999, May. Low Birth Weight is Associated with Reduced Expression of GLUT4 and Carnitiane Palmitoyltransferase-1 in Adult skeletal Muscle. *Diabetes.* V48, pSA274.

2 Low Birth Weight Babies. (1998). *Nevada Kids Count Data Book, 1998*

3 Daltveit, A. K. et al., 1999, June 15. Impact of multiple births and elective deliveries on the trends in low birth weight in Norway. *American Journal of Epidemiology.* V149, p1128.

4 Low Birth Weight Babies. (1999). *Alabama Kids Count 1999 Report*

Infancy – the period from birth to one year

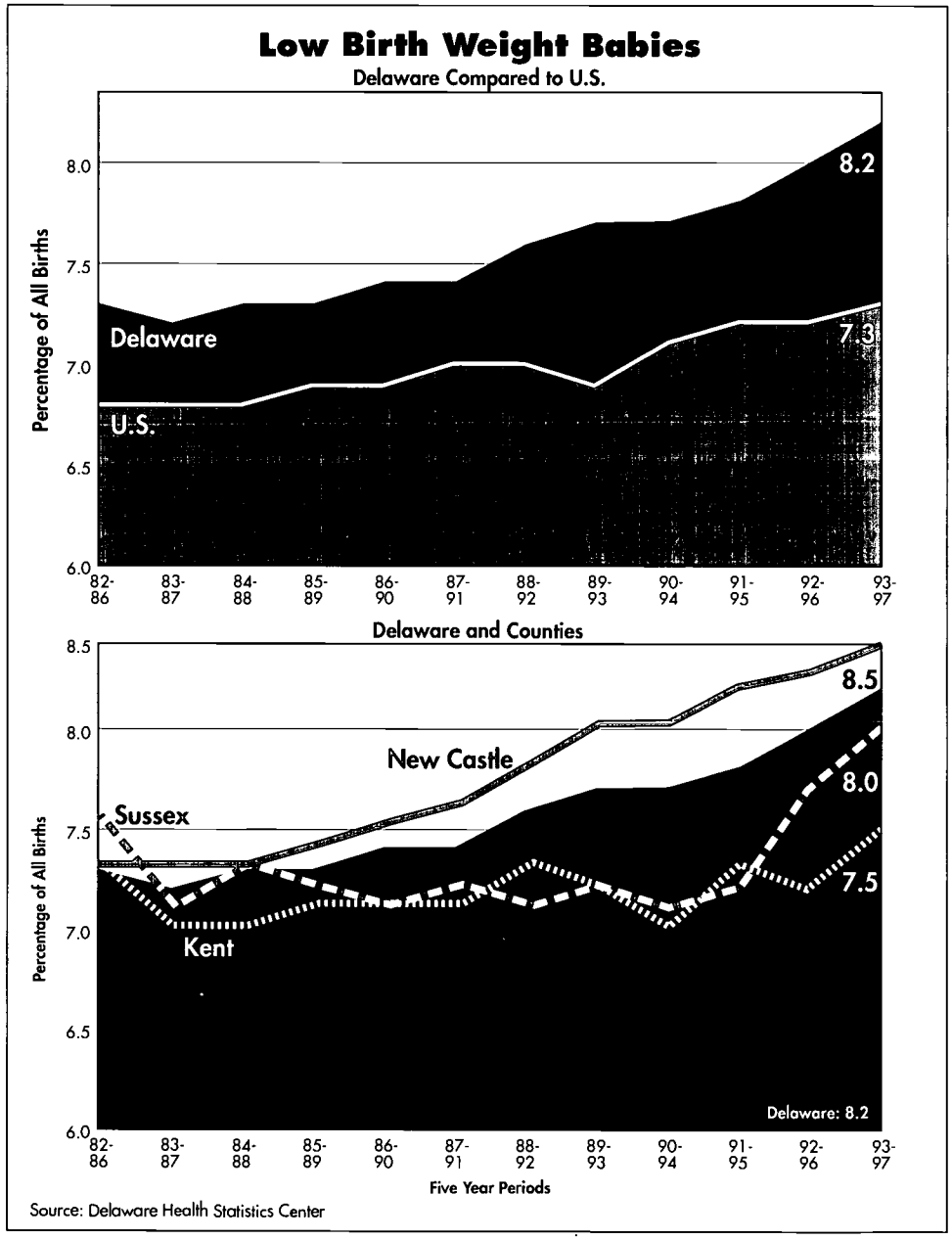
Neonatal – the period from birth to 27 days

Low Birth Weight Babies – infants weighing less than 2,500 grams (5.5 lbs.) at birth (includes very low birth weight)

Very Low Birth Weight – less than 1,500 grams (3.3 lbs.)

Adequate Prenatal Care – frequency and quality as measured by the Kessner Index: The Kessner Index defines adequate prenatal care as (a) the first prenatal visit occurring during the first trimester of pregnancy and (b) periodic visits throughout pregnancy totaling nine or more prenatal visits by the 36th week of gestation. Inadequate care is defined as (a) the first prenatal visit occurring during the third trimester of pregnancy or (b) four or fewer prenatal visits by the 34th weeks of gestation. When the time of the initial visit and the total number of prenatal visits falls between these parameters, the adequacy of prenatal care is rated intermediate.

Birth Cohort – all children born within specified period of time



Percentage of Babies with

Low Birth Weight

(weight less than 2500 grams)
by Age and Race of Mother

Low birth weight babies in Delaware represent:

8.2% of all infants born

10.6% of births to teenagers

8.5% of births to women 20–24 years old

7.2% of births to women 25–29 years old

7.9% of births to women 30+ years old

6.5% of all births to White women

13.5% of all births to Black women

Delaware Average 8.2%

Note: Five-year average percentages, 1993–97

Percentage of Babies with

Very Low Birth Weight

(weight less than 1500 grams)
by Age and Race of Mother

Very low birth weight babies in Delaware represent:

1.7% of all infants born

2.2% of births to teenagers

1.8% of births to women 20–24 years old

1.5% of births to women 25–29 years old

1.6% of births to women 30+ years old

1.2% of all births to White women

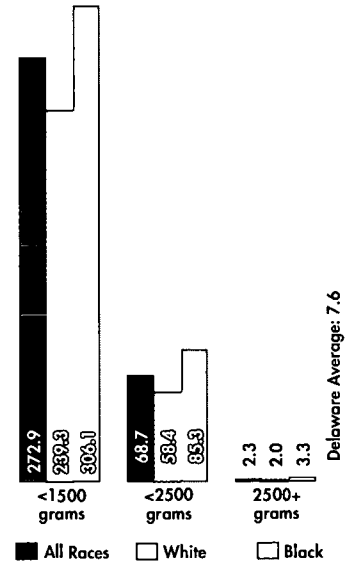
3.3% of all births to Black women

Delaware Average 1.7%

Note: Five-year average percentages, 1993–97

Infant Mortality

per 1,000 Live Births by Birth Weight of Infant and Race of Mother



Note: Five-year average rates, 1992–96
Live Birth Cohort

Percentage of Live Births to Mothers Who Had

Adequate Prenatal Care

by Delaware, Counties, and Wilmington

73.2% of all births in Delaware

78.2% of births to women in New Castle County

67.6% of births to women in Wilmington

80.4% of births to women in New Castle County outside of Wilmington

57.0% of births to women in Kent County

70.2% of births to women in Sussex County

Delaware Average 73.2%

Delaware, 1997

Percentage of Live Births to Mothers Who Had

Adequate Prenatal Care

by Age and Race of Mother

73.2% of all births in Delaware

57.6% of births to teenagers

67.1% of births to women 20–24 years old

77.1% of births to women 25–29 years old

79.8% of births to women 30–34 years old

78.0% of births to women 35+ years old

77.1% of all births to White women

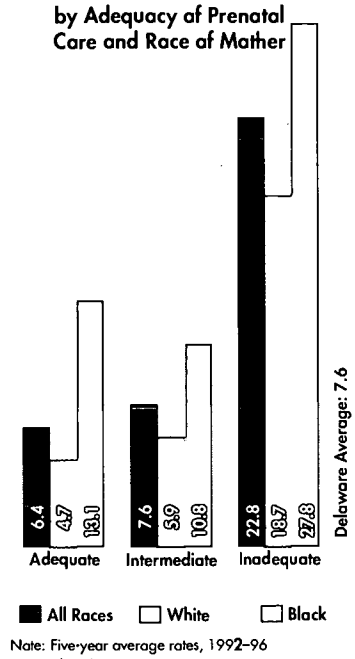
61.4% of all births to Black women

Delaware Average 73.2%

Delaware, 1997

Infant Mortality

by Adequacy of Prenatal Care and Race of Mother



Note: Five-year average rates, 1992–96
Live Birth Cohort

Source for six charts above: Delaware Health Statistics Center

Possible Solutions

Increasing the number of healthy pregnancies will have the greatest impact on low birth weight births. Strategies should include promoting positive prenatal lifestyles, specifically smoking cessation during pregnancy, and increasing access to quality prenatal care that includes early risk assessment and health promotion.

For more information see

In the FAMILIES COUNT Section:

Infant Mortality

The infant mortality rate represents the number of deaths of children under one year old per 1,000 live births. This rate is important because it is associated with a variety of factors, such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices.[1] Certain conditions increase the risk of infant mortality. These risks include maternal age (less than 19 or over 40), timing of pregnancy (leaving less than 18 months between births), poor maternal health or nutrition, and inadequate prenatal care.[2]

According to a national study, poverty is a key factor that affects the life expectancy of a child. The mortality rate for children born into a families in poverty is 50 percent higher than that of children born into families with incomes above the poverty line.[3]

Infant Mortality Rate – number of deaths occurring in the first year of life per 1,000 live births

Birth Cohort – all children born within specified period of time. An infant death in the cohort means that a child born during that period died within the first year after birth.

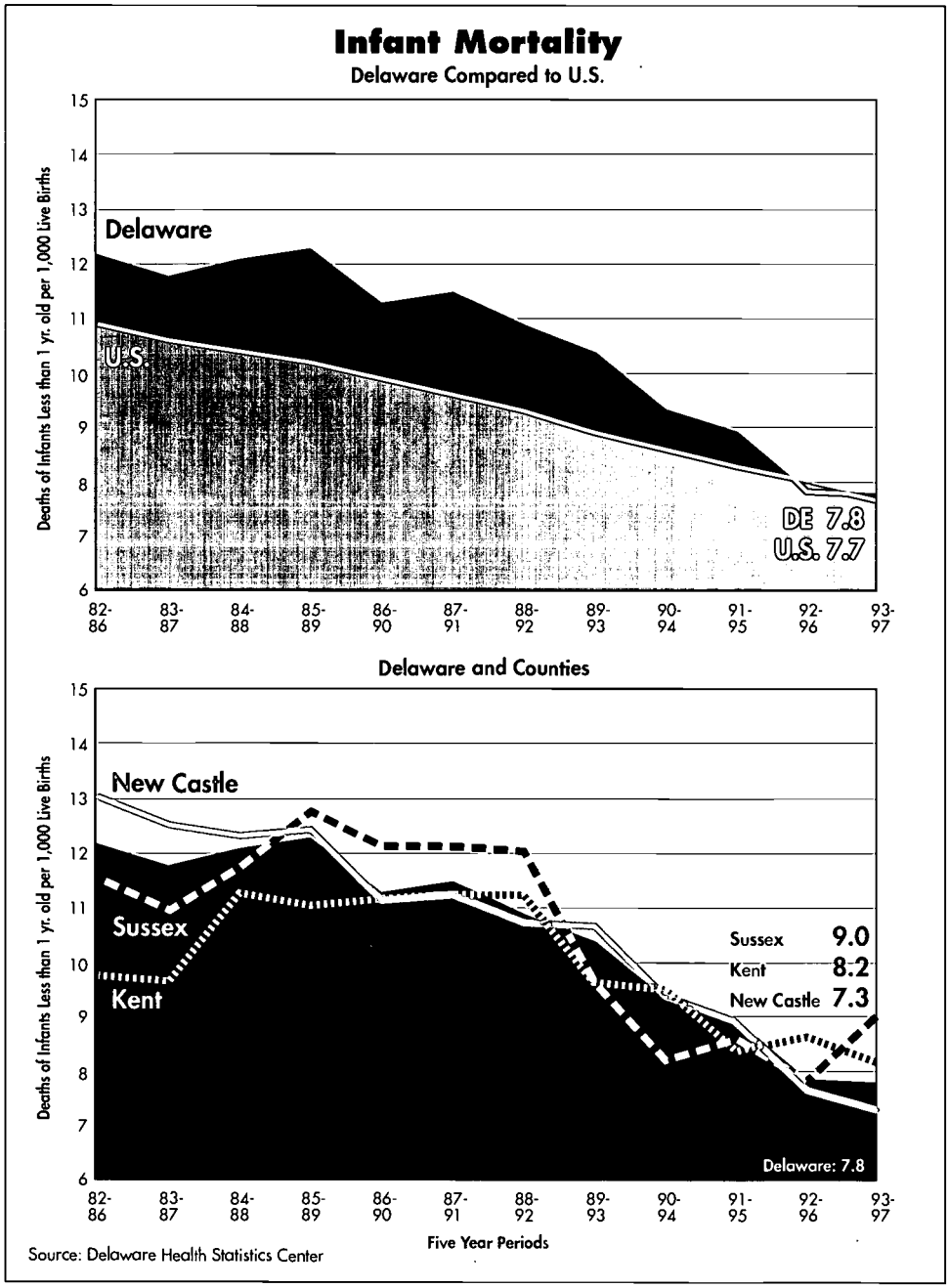
Birth Interval – the time period between the current live birth and the previous live birth to the same mother.

1 America's Children: Key National Indicators of Well-being, 1999

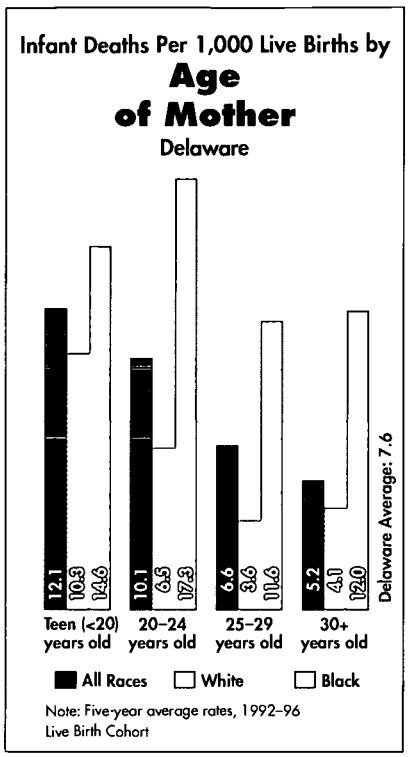
2 Infant Mortality. (1996). *Kids Count Data Book on Louisiana's Children.*

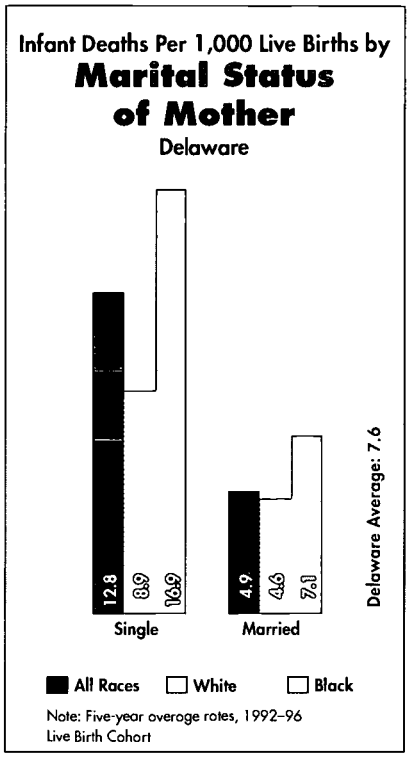
3 1998 Kids Count Databook: *State Profiles of Child Well-Being.* Annie E. Casey Foundation.

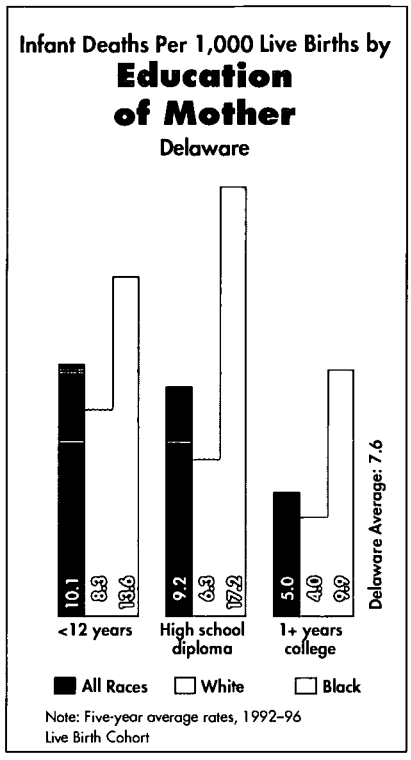
K-22

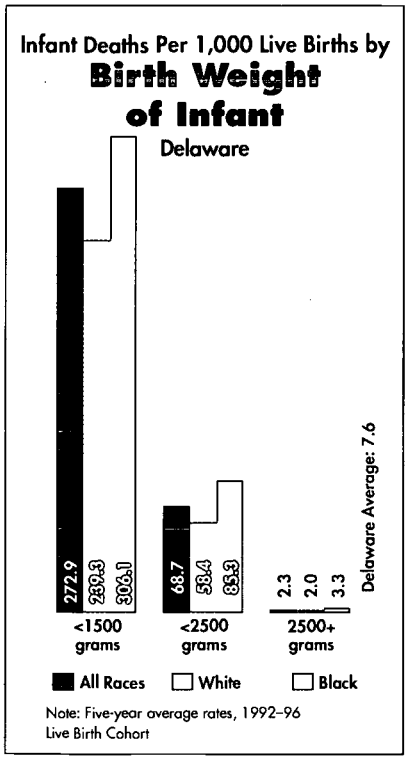


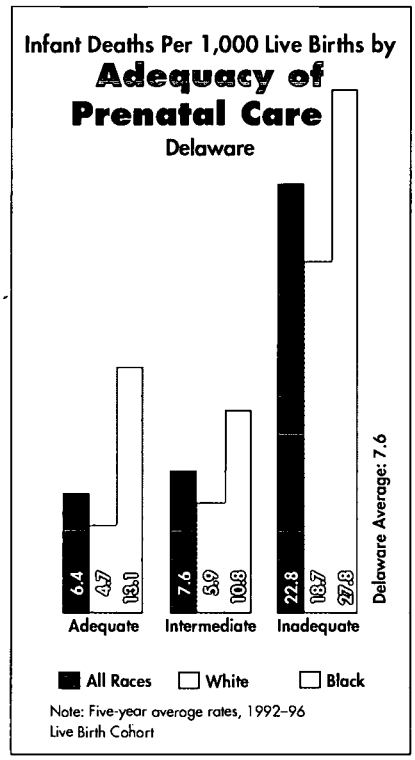
For more information see

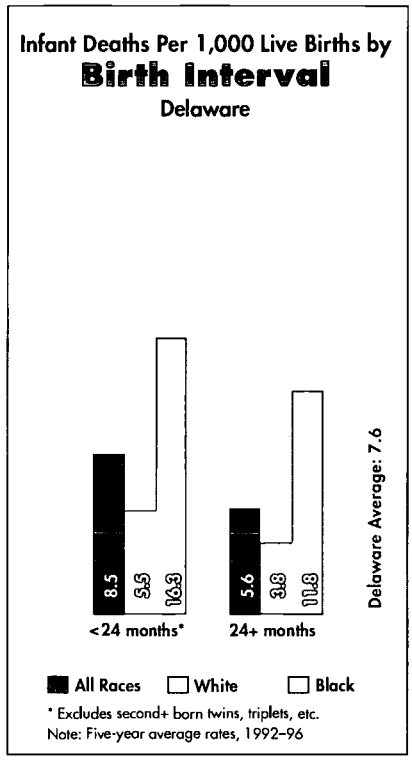












Source for six charts above:
Delaware Health Statistics Center

Possible Solutions

Policies that emphasize healthier pregnancies and reduce low weight infants and premature deliveries, such as universal access to quality prenatal care and substance abuse counseling, will lower the infant mortality rate. Continued advances in medical care will also improve the survival rates of at-risk infants.

Child Deaths Children 1-14 Years of Age

Child Death Rate – number of deaths per 100,000 children 1–14 years old

Unintentional Injuries – accidents, including motor vehicle crashes

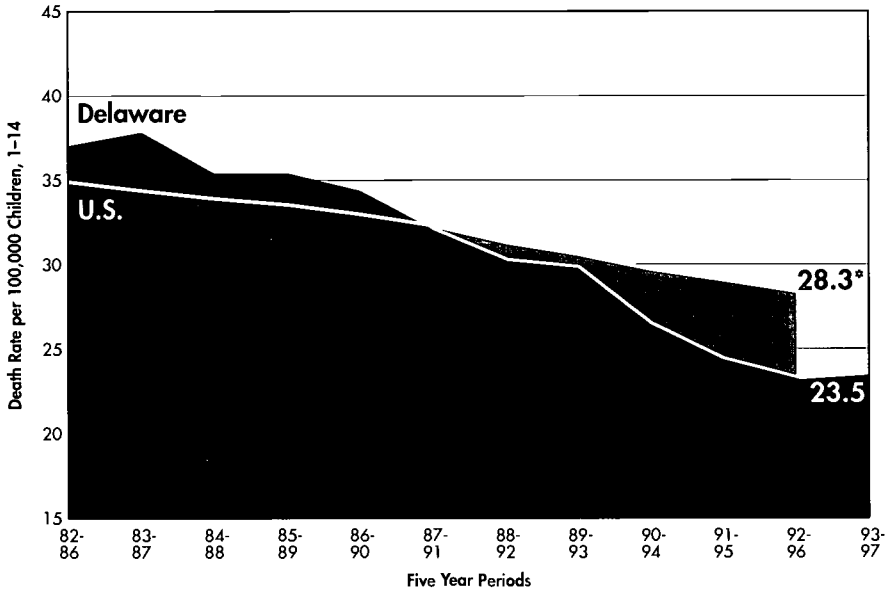
The child death rate is based on the numbers of deaths per 100,000 children divided into two age groups: 1 to 4 and 5 to 14. Poverty is the foremost predictor of injury to children. Overall, lack of parental education, inadequate or lack of health insurance, low birth weight, premature birth, substandard living conditions, substance abuse, child maltreatment, single parent households, and lack of adult supervision are additional risk factors that influence and are associated with child deaths.[1] As a result of technological advances in medical treatment and procedures, the child death rate in the United States has decreased during the past several years. Unintentional injuries remain the leading causes of death for children ages 1 to 4, and most of the injuries are preventable.[2]

1 Child Death Rate. (1998). *Nevada Kids Count Data Book*

2 Lewit, E.M. and Baker, L. S. (1995, Spring). Unintentional Injuries. *The Future of Children*, 5(1).

Child Deaths

Delaware Compared to U.S.



* U.S. data for 1992–1997 was not available

Sources: Delaware Health Statistics Center, National Center for Health Statistics

Number of Children 0–14 Who Died in 1997

in Delaware by County and Age

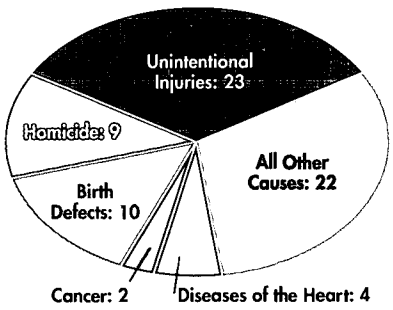
	Under 1	1–4	5–9	10–14
Delaware	81	15	9	11
New Castle Co.	48	7	5	6
Wilmington*	14	2	1	1
Kent Co.	14	4	2	2
Sussex Co.	19	4	2	3

* Wilmington data included in New Castle County total

Source: Delaware Health Statistics Center

Causes of Death of Children 1–4

Delaware, 1993–1997

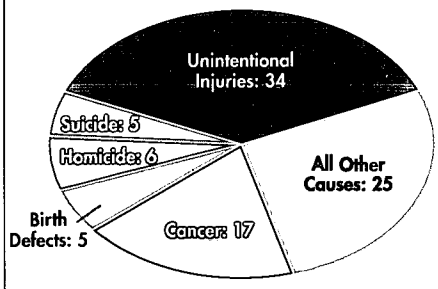


Total Number of Deaths in five-year period: 70 Children

Source: Delaware Health Statistics Center

Causes of Death of Children 5–14

Delaware, 1993–1997



Total Number of Deaths in five-year period: 92 Children

Source: Delaware Health Statistics Center

What We Know

Regarding motor vehicle passenger injuries, in Delaware during the 1992 through 1998 time period:

- 35% of all injured children ages 0 to 4 were in the front seat.
- 43% of severely injured children were in the front seat.
- 60% of children killed were in the front seat.

According to the National Highway Traffic Safety Administration, **the safest place for any child 12 years old and under is in the back seat.**

Each year between 20-25% of all children sustain an injury sufficiently severe to require medical attention, missed school, and/or bed rest.

For every childhood death caused by injury, there are approximately 34 hospitalizations, 1,000 emergency department visits, many more visits to private physicians and school nurses, and an even larger number of injuries treated at home.

Several demographic features are common to most types of injuries. The injury **rates are greatest** in those with:

- **Low socioeconomic status**, especially urban African-American children and American Indians/Alaskan Natives
- **Males**

The principal exception to this is young motor vehicle occupants before adolescence, in whom the male:female ratio is nearly unity.

Source: National Center for Injury Prevention and Control

Possible Solutions

Increased parental education on the importance of using bicycle helmets, car seats and similar safety devices could prevent most injuries.

For more information see

Infant Mortality	p. K-22
Teen Deaths	p. K-26
Health Problems in Law-income Children	p. K-35
Asthma	p. K-43
Child Abuse and Neglect	p. K-48
Tables 18-21	p. K-63-66
Tables 22-24	p. K-66-68
Table 66	p. K-86

In the FAMILIES COUNT Section:

Infant Mortality	p. F-14
Child Deaths	p. F-18
Teen Deaths	p. F-23
Child Abuse	p. F-44

Teen Deaths by Accident, Homicide, and Suicide

With teen violence on the rise, this indicator is frequently highlighted in the media. However, it is important to note that accidents continue to account for far more teen deaths that either homicide or suicide. [1]

Late adolescence poses serious peril to young people. Youth in this age group are almost three times as likely to die as their younger counterparts. With increasing freedom from adult supervision, some youths make choices that put themselves and others in mortal danger. [2] *Teenagers as a group are more willing to take risks, less likely to use safety belts and are more susceptible to the effects of alcohol. Teens with a history of psychiatric disorders, exposure to suicide, disruption of the family, and exposure to violence are at greatest risk for suicide.* [3]

Teen Deaths by Accident, Homicide, and Suicide –
number of deaths per 100,000 teenagers 15-19 years old

Unintentional Injuries – accidents, including motor vehicle crashes

1 Teen Deaths. (1998). *Indiana Kids Count 1998 Databook.*

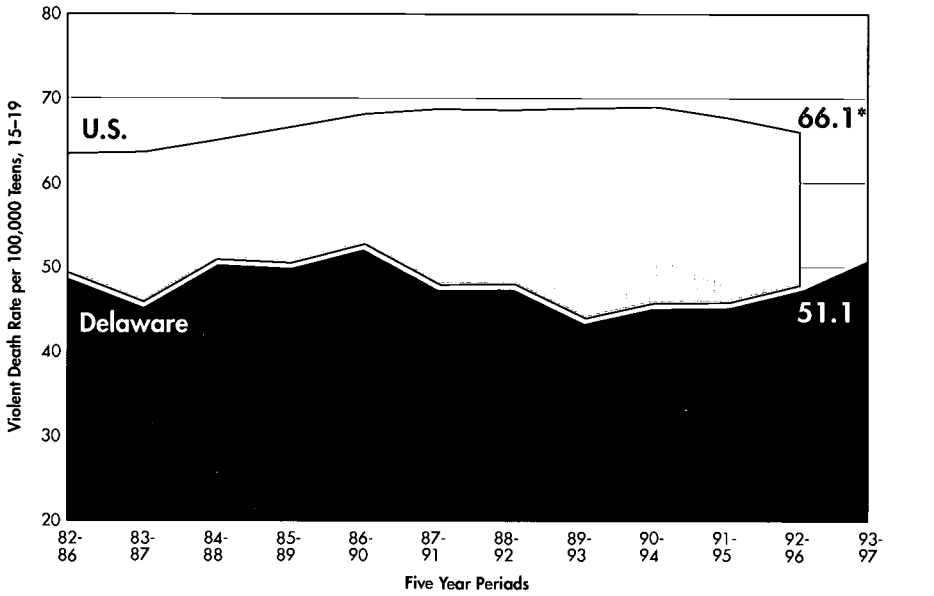
2 Teen Deaths. (1999). *Kids Count in Michigan, 1999 Databook.*

3 Teen Deaths. (1998). *Alabama Kids Count 1998 Report.*

K-26

Teen Deaths by Accident, Homicide, and Suicide

Delaware Compared to U.S.



* U.S. data for 1993–1997 was not available

Sources: Delaware Health Statistics Center, National Center for Health Statistics

Deaths by Accident, Homicide, and Suicide of Youth 15–19 in 1997

in Delaware by Cause

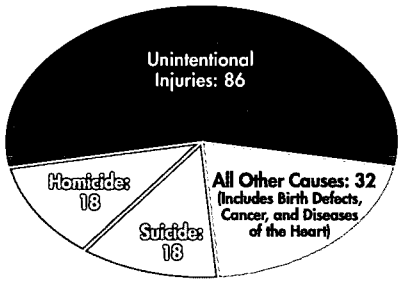
Homicide	3 males and 1 female
Suicide	6 males and 0 females
Motor Vehicle Crashes	12 males and 5 females
Other Unintentional Injuries	3 male and 2 female

Total Number of Deaths: 32 Teens

Source: Delaware Health Statistics Center

Causes of Death of Teens 15–19

Delaware, 1993–1997



Total Number of Deaths: 154 Teens

Source: Delaware Health Statistics Center

Special DUI Laws in Delaware

Zero Tolerance: If you are under 21 and you are arrested for DUI with a blood alcohol level of .02* or higher, you will lose your license automatically: for the first offense it's for 2 months, second offense is 6 months, third offense is 1 year. If you don't have a license you can be fined $200 for the first offense and between $400 and $1,000 for any subsequent offenses.

Underage Consumption: If you are caught with alcohol (anywhere, not just in a car) and you are under 21, you will automatically lose your license for 1 to 6 months. If you do not have a license, you will be fined between $100 and $500.

DUI – Driving Under the Influence: If you drive with a blood alcohol level of more than .1%, you could face up to 1 year in prison and a fine of $230 for the first offense. For the third and all subsequent offenses, DUI is a felony. That means anywhere from 2 to 5 years in prison and a fine of not less than $2,000.

In addition to the above penalties and costs, DUIs cost you $143.75 to get your license back and $490 to take an alcohol program.

Source: Drug-Free Delaware DUI Stats, www.state.de.us/drugfree/duistats

* Zero Tolerance means zero: A blood alcohol level of .02 is the amount of alcohol in a dose of cough syrup.

Possible Solutions

Policies that increase seat belt usage and limit teen access to alcohol should decrease the number of teen deaths from accidents. Successful teen violence prevention efforts include teaching alternatives to aggression, mentoring programs, targeted media messages, and individual and group counseling. Suicide prevention begins with closer parent-child relationships and alertness to changes in behavior.

For more information see

Infant Mortality	p. K-22
Child Deaths	p. K-24
Alcohol, Tobacco, and Other Drugs	p. K-46
Juvenile Violent Crime Arrests	p. K-28
Tables 24-30	p. K-68-71

In the FAMILIES COUNT Section:

Infant Mortality	p. F-14
Child Deaths	p. F-18
Substance Abuse	p. F-20
Teen Deaths	p. F-23

Juvenile Violent Crime Arrests

Juvenile Violent Crime Arrest Rate – number of arrests for violent crimes per 1,000 children 10–17; includes homicide, forcible rape, robbery, and aggravated assault

This rate tracks arrests of juveniles, ages 10 through 17, for the crimes of homicide, forcible rape, robbery, and aggravated assault per 100,000 youths. The continuing problem of drug abuse, the increasing availability of weapons, and the growth of gangs have contributed to rising juvenile violence.[1] However, it should be noted that children in this age group are more likely to be victims of violent crime rather than perpetrators of such crime.[2] Risk factors for violent crime arrests include poverty, family violence, inadequate supervision, limited education or job skills, and poor performance in school.[3]

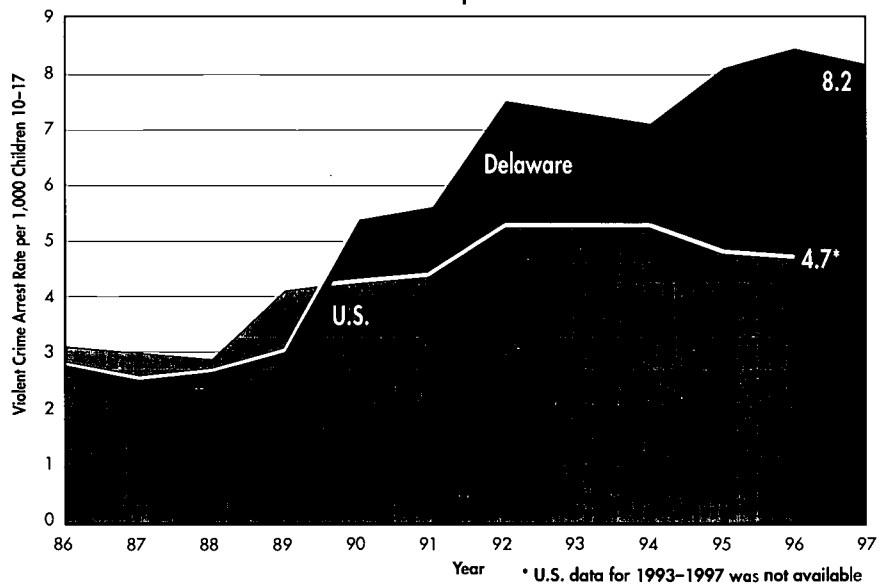
1 Juvenile Violent Crime Arrests. (1998). *Alabama Kids Count 1998 Report.*

2 Juvenile Violent Crime Arrests. (1998). *Nevada Kids Count Databook.*

3 Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice (1995). *Juvenile Offenders and Victims, A National Report.*

Juvenile Violent Crime Arrests

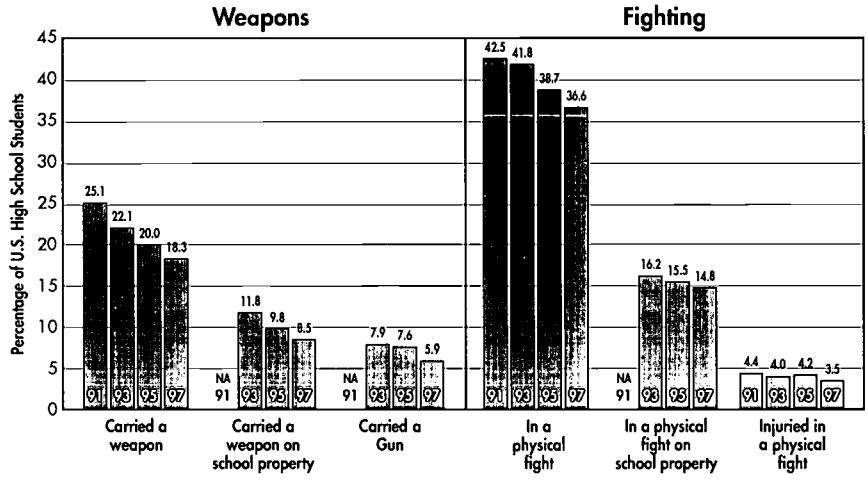
Delaware Compared to U.S.



* U.S. data for 1993–1997 was not available

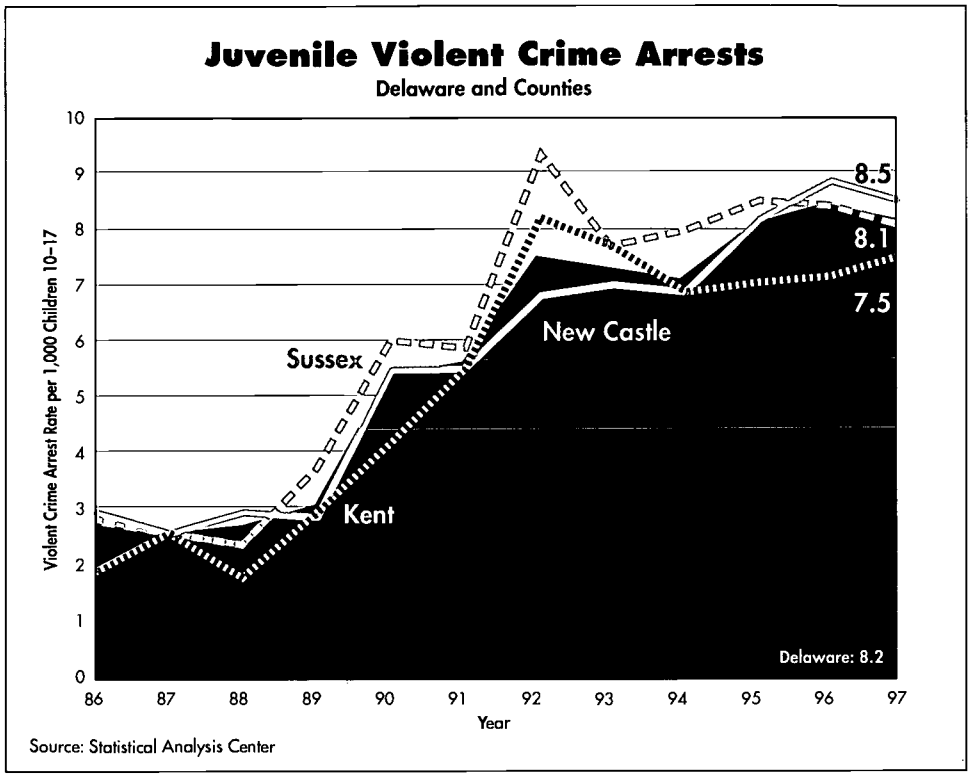
Source: Statistical Analysis Center

Violence-Related Behavior



Despite widely publicized incidents recently, violent behavior among teens has decreased significantly over the past decade. The number of teens carrying weapons showed the most dramatic decline.

Source: Recent Trends in Violence-Related Behavior Among High School Students in the United States, *Journal of the American Medical Society*, August 4, 1999

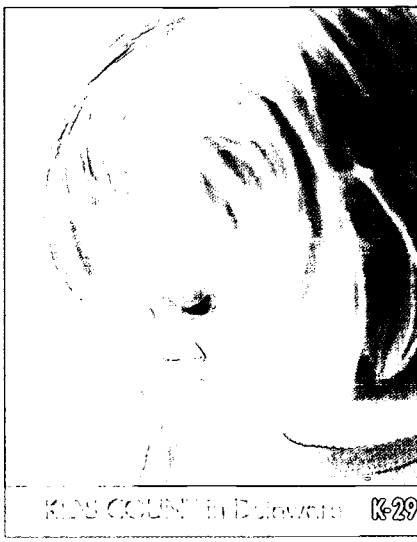


Source: Statistical Analysis Center

Student Violence and Possession

Delaware Code, Title 14 §4112, signed in July 1993, required that evidence of certain incidents of student conduct occurring in Delaware schools be reported to the Secretary of Education and to the Youth Division of the Delaware State Police. The State Board of Education expanded the reporting requirements of Title 14 to include evidence of other incidents involving school children such as reckless endangering, unlawful sexual conduct, or robbery.

In 30% (569) of the incidents, police charges were filed. In 191 of the incidents, possession and or concealment of dangerous instruments were involved. Possession of unlawful controlled substances accounted for an additional 237 incidents.



The vast majority of students feel safe in school. However, only 64% of 5th graders think that kids at school **obey their teachers**, and only 19% of 8th graders and 22% of 11th graders think students **treat their teachers with respect** most of the time. The number of students interviewed who report **taking a weapon to school** slightly declined in 1998 to 4% of 8th graders and 5% of 11th graders.

Source: Alcohol, Tobacco, and Other Drug Abuse Among Delaware Students, 1998, The Center for Drug and Alcohol Studies and The Center for Community Development and Family Policy, University of Delaware

Possible Solutions

More resources for alternative schools, juvenile probation officers, after-school programs, juvenile justice intervention programs and safe school measures could prevent much of the tragedy that results from juvenile crime.

For more information see

Teen Births, Did You Know	p. K-17
Teen Deaths	p. K-26
Tables 26-38	p. K-69-74

In the FAMILIES COUNT Section:

Teen Deaths	p. F-23
Juvenile Delinquents in Out-of-Home Care	p. F-46
Juvenile Violent Crime	p. F-53
Adult Violent Crime	p. F-54
Adults on Probation or Parole	p. F-55

High School Dropouts

Students who drop out of high school face staggering odds in achieving economic success in the modern world. High school graduation is a minimum prerequisite to compete effectively in today's labor market.[1] Education is one of the most important factors that determines annual earnings that, in turn, are a direct link to one's socioeconomic status.[2] Students are more likely to drop out of school when they are poor, when they live in poor communities, or when they come from single-parent homes.[3] Potential warning signs that a child may drop out of high school include the inability to read at grade level, poor grades, truancy, substance abuse, and teen pregnancy.[4]

Teens Not Graduated and Not Enrolled – youths 16–19 who are not in school and not high school graduates

1 High School Dropouts. (1998). *Nevada Kids Count Data Book.*

2 U.S. Department of Education, National Center for Education Stats. (1998, November 3). Education indicators: an international perspective.

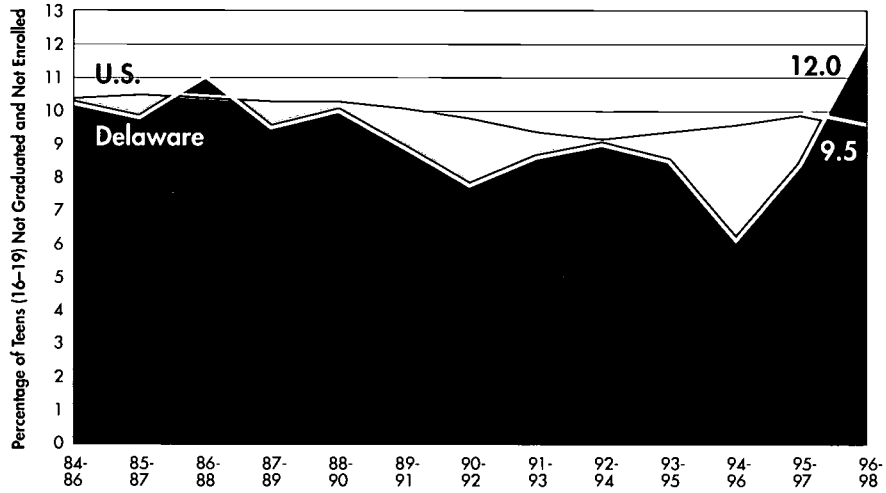
3 Annie E. Casey Foundation. (1998). Kids Count Data Book.

4 Children's Defense Fund. (1995). The State of America's Children Yearbook.

K-30

Teens Not Graduated and Not Enrolled

Teens 16–19 Years Old
Delaware Compared to U.S.



Note: Variations in the Delaware graph are due to sampling size of the data collection. Data are collected through a sample size too small for county breakout.

This measure is based on an analysis of the Current Population Survey, representing a nationwide sampling. Like all estimates derived from sampling, these figures do contain sampling errors. The Bureau of Labor Statistics suggests that state rankings based on these figures should be used with caution.

Source: Center for Applied Demography and Survey Research, University of Delaware

Parenthood is cited as the reason for dropping out of school by more than 25% of girls. Nearly 8% of the boys said they left school because they became a parent.

The most common reason cited for dropping out: I dislike school!!!!

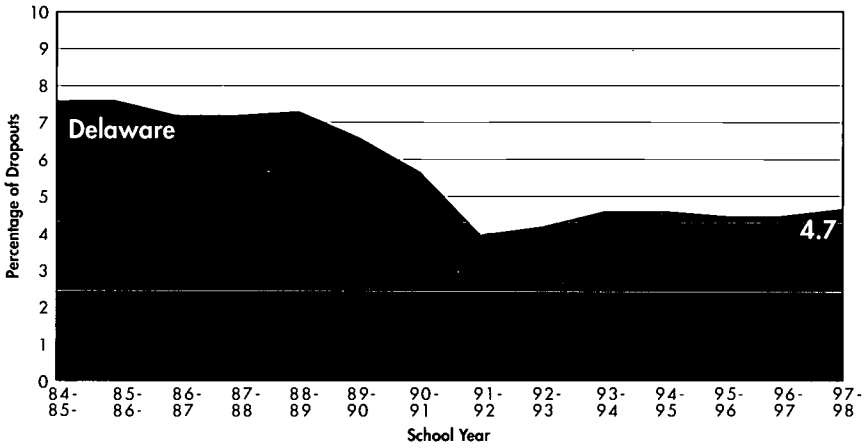
Source: Dropouts: Why they leave school, www.cyfc.umn.edu)

Possible Solutions

Programs designed to keep our children connected to school by teaching them the value of learning and keeping them engaged through challenging courses that expand their minds may reduce high school dropouts.

Public High School Dropouts

Grades 9–12, Delaware

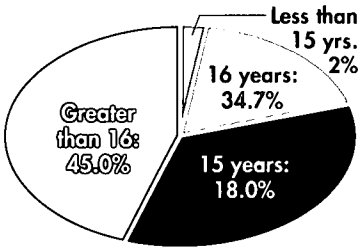


This data, provided by the Delaware Department of Education, reparts information from the state's secondary schools. Delaware is one of the states that currently has the capability to maintain a complete dropout database at the state level which contains individual student records, rather than aggregate counts.

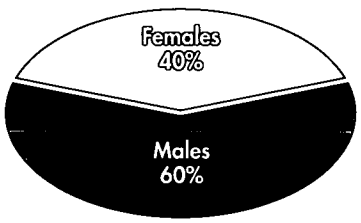
Source: Delaware Department of Education

Percentage of Dropouts

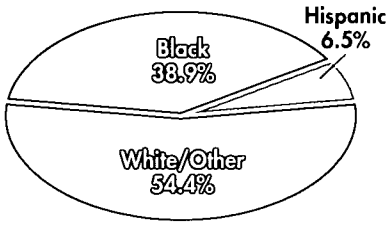
by Age, Gender, and Racial/Ethnic Group



% of all dropouts by age*



% of all dropouts by gender

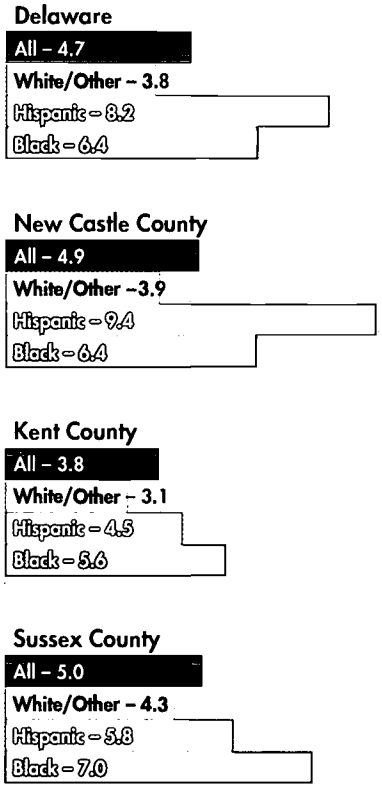


% of all dropouts by racial/ethnic group

School Year 1997–1998
Source: Delaware Department of Education

Dropout Rates

by Racial/Ethnic Group



Delaware Average: 4.7

School Year 1997–1998
Source: Delaware Department of Education

K-31

For more information see

Infant Deaths by Education of the Mother	p. K-23
Teens Not in School and Not Working	p. K-32
Suspensions and Expulsions	p. K-33
Table 20	p. K-65
Tables 39-46	p. K-75-78
Table 61	p, K-84
In the FAMILIES COUNT Section:	
Student Achievement	p. F-28
Teens Not in School and Not Working	p. F-30
High School Dropouts	p. F-31

Teens Not in School and Not Working

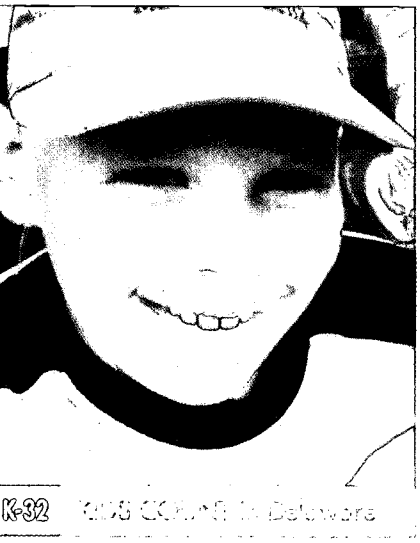
Teens Not in School and Not Working – teenagers 16–19 who are not in school and not employed

The indicator "teens not in school and not working" is defined as youths ages 16-19 who are not enrolled in school and are unemployed. This indicator includes recent high school graduates who are unemployed and teens who have dropped out of high school who are jobless. Work experience at this point in life is critical. People who spend a large share of their young adult years unemployed have a hard time finding and keeping a job later in life. [1]

Teens who are not in school and are not working are at increased risk of juvenile delinquency, substance abuse, juvenile crime, teen pregnancy, and lifelong poverty. Teens who have dropped out of high school are most vulnerable and at greatest risk. Gaps in schooling and lack of general preparation for the workforce also place teens at considerable risk as they make the difficult transition from adolescent to adulthood. [2]

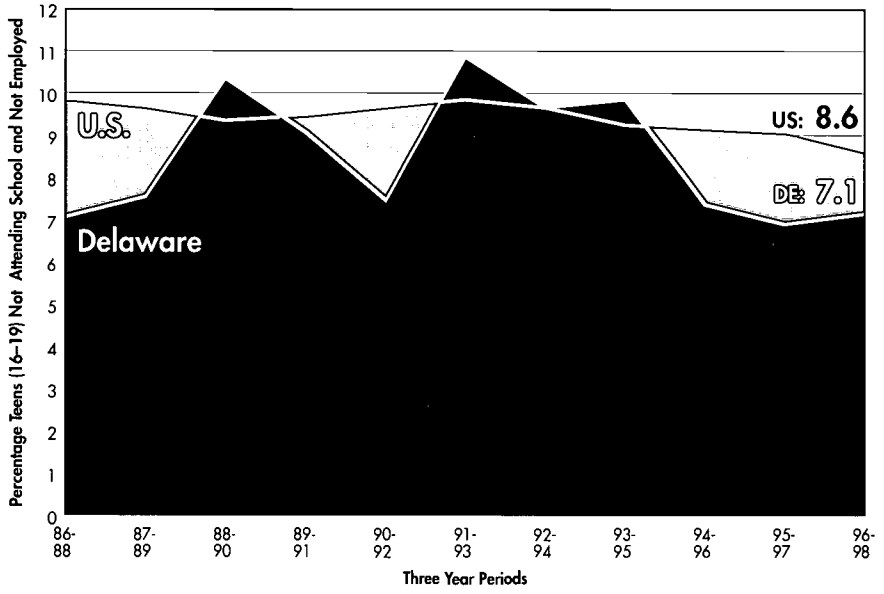
1 Teens not in school and not working. (1999). *National Kids Count Data Book.*

2 Teens not in school and not working. (1998). *Nevada Kids Count Databook.*



Teen Not in School and Not Working

Delaware Compared to U.S.



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This measure is based on an analysis of the Current Population Survey, representing a nationwide sampling. Like all estimates derived from sampling, these figures do contain sampling errors. The Bureau of Labor Statistics suggests that state rankings based on these figures should be used with caution.

Source: Center for Applied Demography and Survey Research, University of Delaware

Suspensions and Expulsions

The State of Delaware's Department of Education keeps track of out-of-school suspensions and expulsions in all regular, vocational/technical, and special public schools for each school year. During the 1996-97 school year, a total of 27,174 out-of-school suspensions were reported by Delaware's 19 school districts. Three percent of these suspensions occurred in grades K-3. About 44% of the suspensions were students from grades 4–8 and the remaining 53% of suspensions happened in the high school level, grades 9–12. Suspensions were the result of various infractions, including fighting (15%) and defiance of authority (17%). Approximately 340 students were absent each day due to suspensions, totaling about 61,000 days missed. The number of students involved in the incidents which resulted in suspension was 12,664, of which 68% were male.

It is important to understand that the duration of out-of-school suspensions is influenced by district policy, district procedure, severity of the incident, frequency of a particular student's involvement in disciplinary actions, and the availability of disciplinary alternatives.

Suspensions in Delaware Schools, 1996-97

County	Number of Suspensions	Number of Students Who Were Suspended	Enrollment	Percentage of Enrollment Who Were Suspended
Delaware	27,174	12,664	110,279	11%
New Castle	18,852	8,608	64,921	13%
Kent	4,127	2,073	24,564	8%
Sussex	4,195	1,983	20,794	10%

Source: Delaware Department of Education

Expulsions in Delaware Schools, 1996-97

County	Number of Expulsions	Enrollment	Percentage of Enrollment Who Were Expelled
Delaware	171	110,279	0.2%
New Castle	82	64,921	0.1%
Kent	38	24,564	0.2%
Sussex	51	20,794	0.2%

Source: Delaware Department of Education

Possible Solutions

Initiatives that reinforce the importance of staying in school, pursuing secondary education and preparing for the workforce so that teens can lead more productive lives could lower this rate.

For more information see

High School Dropouts p. K-30

Tables 39-46 p. K-75-78

Table 61 p. K-84

In the FAMILIES COUNT Section:

Student Achievement p. F-28

Teens Not in School and Not Working p. F-30

High School Dropouts p. F-31

Unemployment p. F-50

Children in Poverty

Children in Poverty – percentage of children in poverty; in 1997 the poverty threshold for a one-parent, two child family was $13,133. For a family of four with two children, the threshold was $16,530.

Poverty is related to all of the KIDS COUNT indicators. It is defined as the condition of not having enough income to meet basic needs for food, clothing, and shelter.[1] The 1997 poverty threshold for a family of four was $16,530 per year. Poverty has been found to be linked to a number of undesirable outcomes for children, including health, education, child abuse and neglect, delinquency, and emotional well-being.[2] Children who live in single-parent families with poorly educated, relatively young, minority race, or disabled adults are more likely to be poor and to experience longer poverty spells than children who do not live in such families.[3]

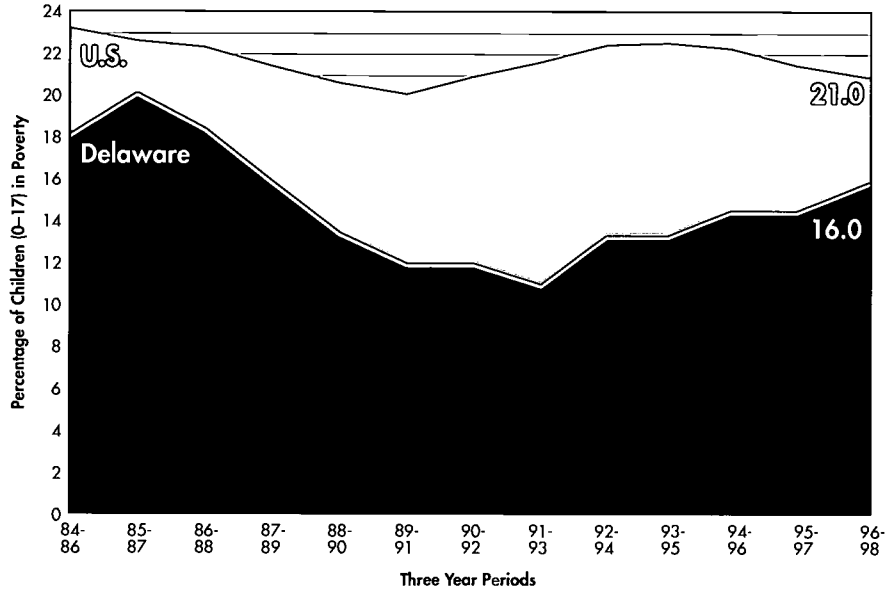
1 Future of children: the effects of poverty on children. (1997, Summer-Fall). *The Center of the Future on Children*, 7(2).

2 Children in Poverty. (1999). *Kansas Kids Count Databook.*

3 Center for the Future of Children. The David and Lucille Packard Foundation. (1997). *The Future of Children: Children and Poverty.* V. 7 n2.

Children in Poverty

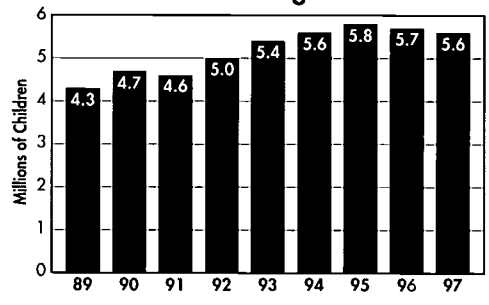
Delaware Compared to U.S.



Source: Center for Applied Demography and Survey Research, University of Delaware

While recent public policy discussions have focused on children in welfare-dependent families, during the 1990s there has been a significant increase in children in working-poor families (where at least one parent worked 26 or more weeks, and family income was below poverty level). In the U.S., the number of children living in working-poor families increased from 4.3 million in 1989 to 5.6 million in 1997.

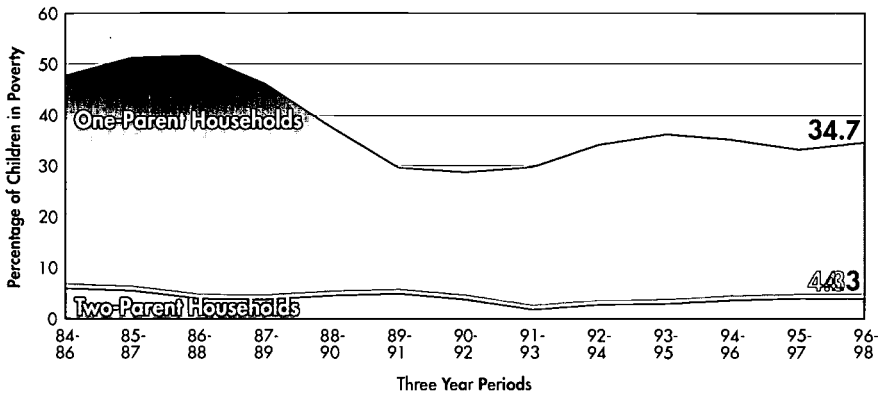
Children in Working-Poor Families



Source: National *KIDS COUNT Data Book 1999*

Children in Poverty by Household Structure

Delaware



Source: Center for Applied Demography and Survey Research, University of Delaware

For more information see

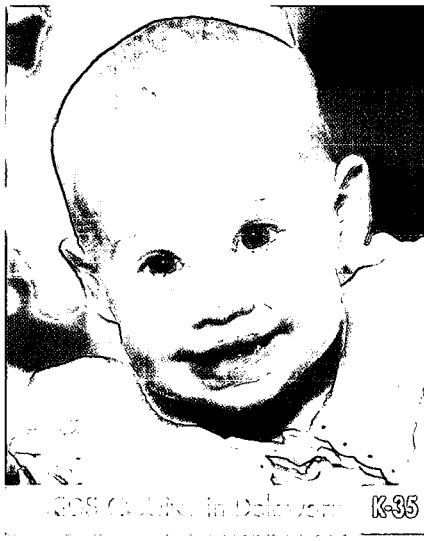
Median Income of Families by Family Type	p. K-37
Child Care Costs	p. K-39
Subsidized Child Care	p. K-39
Children Receiving Free and Reduced Price School Meals	p. K-41
Women and Children Receiving WIC	p. K-42
Children without Health Insurance	p. K-44
Tables 46-58	p. K-78-82
Table 65	p. K-85

continued below

The frequency of health problems is higher in low-income children compared to other children—often two, three, or four times as high. Relative frequencies of health problems of low-income children compared with other children in the U.S. are listed below.

Relative Frequency in Low-income Children	Health Problem
2x	Low birth weight
2–3x	Postneonatal mortality
2–3x	Child deaths due to accidents
3–4x	Child deaths due to disease
3x	Delayed immunization
2x	Diabetic ketoacidosis
2x	Severe iron-deficiency anemia
2–3x	Rheumatic fever
2–3x	Complications of bacterial meningitis
2–3x	Conditions limiting school activity
2–3x	Severely impaired vision
3x	Lead poisoning

Source: Colorado KIDS COUNT Data Book; B. Starfield, "Child and Adolescent Health Status Measures," The Future of Children, Vol. 3 No. 2, Winter 1992



continued from above

For more information see

In the FAMILIES COUNT Section:

Health Care Coverage	p. F-19
Children in Poverty	p. F-34
Female Headed Households in Poverty	p. F-38
Child Support	p. F-39
Risk of Homelessness	p. F-40
Health Care Coverage	p. F-41
Unemployment	p. F-50
Substandard Housing	p. F-56
Home Ownership	p. F-57

Possible Solutions

Programs that encourage teens to complete high school and to marry before having children will decrease the number of children born into poverty. Improved job training and apprenticeship programs combined with affordable, high-quality childcare will also help move families out of poverty.

Children in One-Parent Households

Children living in single-parent families do not have the same resources and opportunities as those living in two-parent families.[1] When the single parent is a woman, the risk of sinking into poverty is significantly greater due to the wide earnings gap between men and women in the United States. Many single mothers also receive insufficient child support, which puts their children at greater risk for all the adverse outcomes linked to poverty.[2]

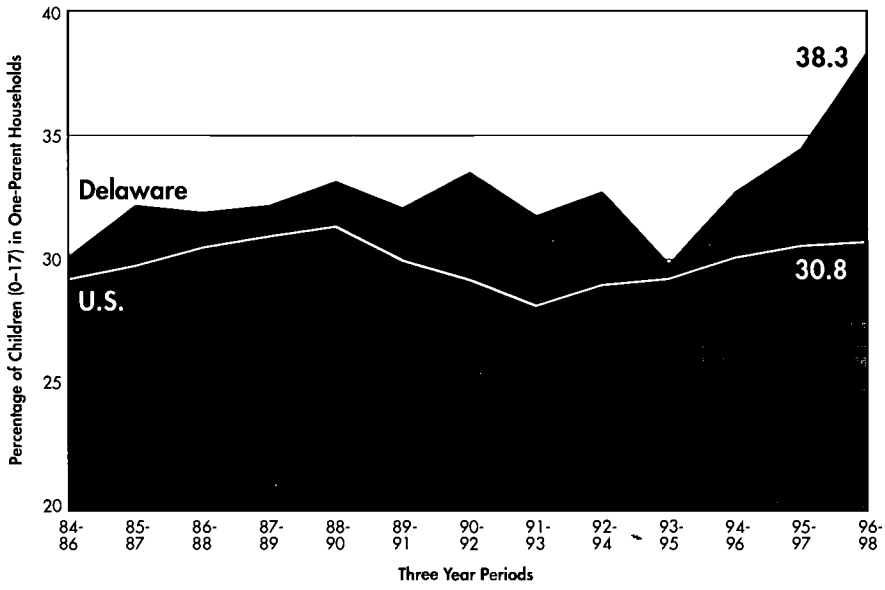
High divorce rates and high non-marital birth rates indicate that a record number of children are growing up without fathers in their lives. For the first time in history, the average child can expect to live a significant portion of his or her life in a home without a father.[3]

Children in One-Porent Households – percentage of all families with "own children" under age 18 living in the household, who are headed by a person – male or female – without a spause present in the home. "Own children" are never-married children under 18 who are related to the householder by birth, marriage, or adoption.

1 U.S. Bureau of Census, 1997, *Census Brief: Children with Single Parents - How they fare*, U.S. Department of Commerce, Bureau of the Census, Washington, D.C.

2 Corocan, Mary E. and Ajay Chaudry, 1997, "The Dynamics of Childhood Poverty," *The Future of Children: Children and Poverty*, The David and Lucille Packard Foundation, Los Altos, CA, Vol. 7, No. 2, Summer/Fall

3 Tennessee Kids Count. 1999. *The State of the Child in Tennessee.*



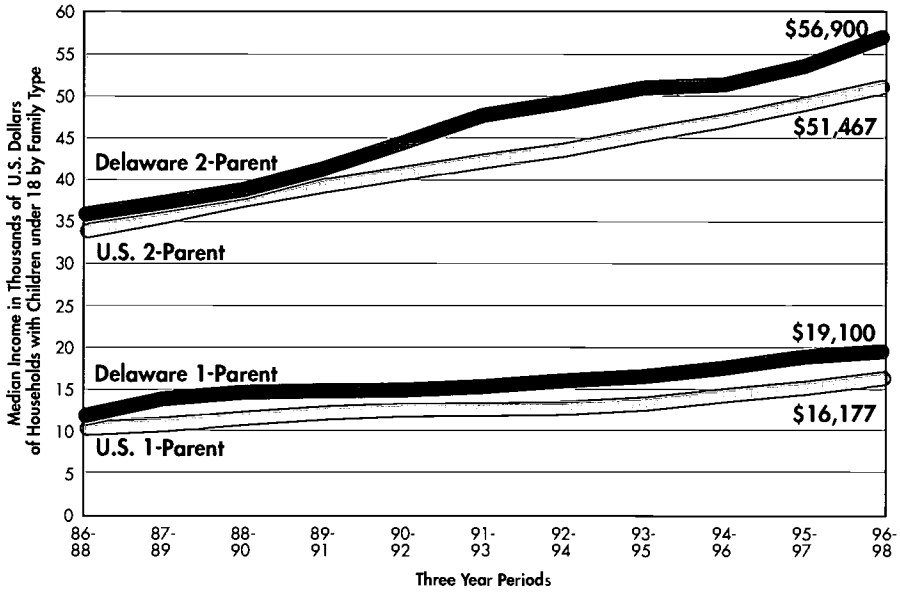
Source: Center for Applied Demography and Survey Research, University of Delaware

Possible Solutions

Policies that enforce child support, including awards that reflect the cost of raising children, could improve the economic well-being of single-parent households.

Median Income of Families with Children by Family Type

Delaware and U.S.



Source: Center for Applied Demography and Survey Research, University of Delaware

Percentage of Births to Single Mothers

in Delaware by County, Age, and Race
Five-year Average, 1993–97

35.0% of all births in Delaware

32.7% of births to women in New Castle County

35.3% of births to women in Kent County

43.2% of births to women in Sussex County

89.1% of births to teenagers in Delaware

54.2% of births to women 20–24 years old in Delaware

21.7% of births to women 25–29 years old in Delaware

13.5% of births to women 30+ years old in Delaware

35.0% of all births in Delaware

31.6%* of all births in the U.S.

23.7% of all births to White women in Delaware

24.5%* of all births to White women in the U.S.

72.9% of all births to Black women in Delaware

69.7%* of all births to Black women in the U.S.

Delaware Average 35.0%

* U.S. data are for 1992–96. 1993-97 data were not available.

Source: Delaware Health Statistics Center

For more information see

Birth to Unmarried Teens	p. K-19
Infant Mortality by Martial Status of Mother	p. K-23
Children in Poverty by Household Structure	p. K-35
Table 7	p. K-56
Table 20	p. K-65
Tables 47-62	p. K-78-84

In the FAMILIES COUNT Section:

One-Parent Households	p. F-35
Female Headed Households in Poverty	p. F-38
Child Support	p. F-39

Early Care and Education and School-Aged Child Care

Common sense has always told us that babies benefit from an environment of love, nurturing, and stimulation. Now, new medical research confirms the notion that the experiences of children in the first three years of life determines, to a large degree, the brightness of their future.[1] Children's brains show almost twice the activity of an adult brain until the age of ten. Therefore, high quality early education opportunities for young children are essential and need to be available to children in all of their environments, including child care outside of the home. Further studies indicate that the quality of child care is important because it is closely linked with children's social, cognitive, and language development. Children in high quality early childhood programs are more likely to be emotionally secure and self-confident, proficient in language use, able to regulate impulsive and aggressive inclinations, and advanced in cognitive development.[2]

An ever increasing number of parents juggle work schedules and child care needs with availability of family financial and human resources to meet the demands of parental and employment responsibilities.[3] One obstacle that many working parents encounter is the limited availability of affordable child care. Even when cost is not an insurmountable barrier, many families find that child care is simply not available at the times and places it is needed.

1 Colorado's Children's Campaign, (1998). *Kids Count in Colorado.*

2 Tennessee Kids Count, (1999). *The State of the Child in Tennessee.*

3 Michigan Kids Count. (1999). *Michigan Kids Count Databook 1999.*

Accredited Programs

Number of Accredited Programs by Accrediting Organization*
Delaware and Counties, 1998

	NAFCC	NAEYC	NSACA
Delaware	37	23	0
New Castle County	28	18	0
Kent/Sussex Counties	9	5	0

Source: The Family and Workplace Connection
* NAFCC is the National Association for Family Child Care Providers
* NAEYC is the National Association for the Education of Young Children
* NSACA is the National School Age Care Alliance

Quality: Early childhood programs can be classified on a continuum between services that are educational which attend to child development and services that provide primary custodial care while parents are at work. Research has shown that the way children function, from the preschool years, through adolescence, and into adulthood, hinges in large part on their experiences before the age of three[1]. Therefore, all programs for young children should include both quality education and care[2]. Combining all child care and early education issues provides a clearer picture of the quality and quantity of services that children receive.

1 "I Am Your Child" (1997). Early Childhood Engagement Campaign.

2 *Years of promise: A comprehensive learning strategy for America's children.* (1996). New York: Carnegie Corporation of New York.

Staff/Child Ratios

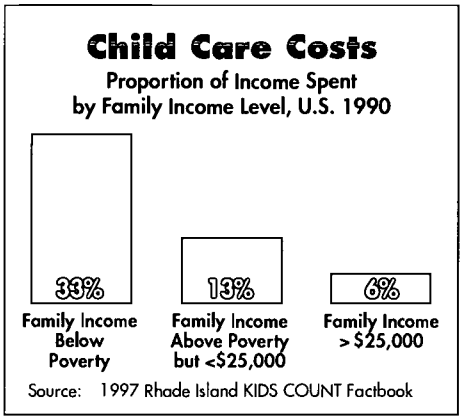
Licensing Requirements vs. Accreditation Recommendations
Staff to Child Ratios

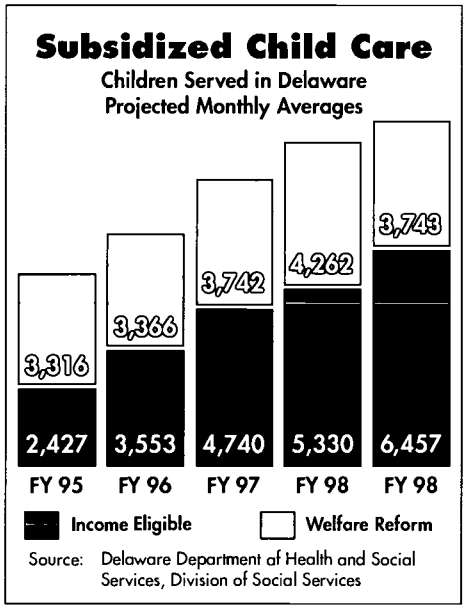
Age of Child	# Children Allowed per Caregiver in Delaware	NAEYC Recommended Level
9 month	4	3–4
18 month	7	3–5
27 month	10	4–6
3 years	12	7–10
4 years	15	8–10

Source: Children's Defense Fund. (1996, May). Delaware: child care challenges.

Cost: The cost of full-time child care often represents the largest expense, after housing, for working parents who need full-time care for their children. The less families earn, the higher the proportion of income spent on child care [1].

1 Phillips and Anne Bridgman (eds.). *New findings on children, families, and economic self-sufficiency.* (1995). Washington, DC: Board on Children and Families, national Research Council, Institute of Medicine.

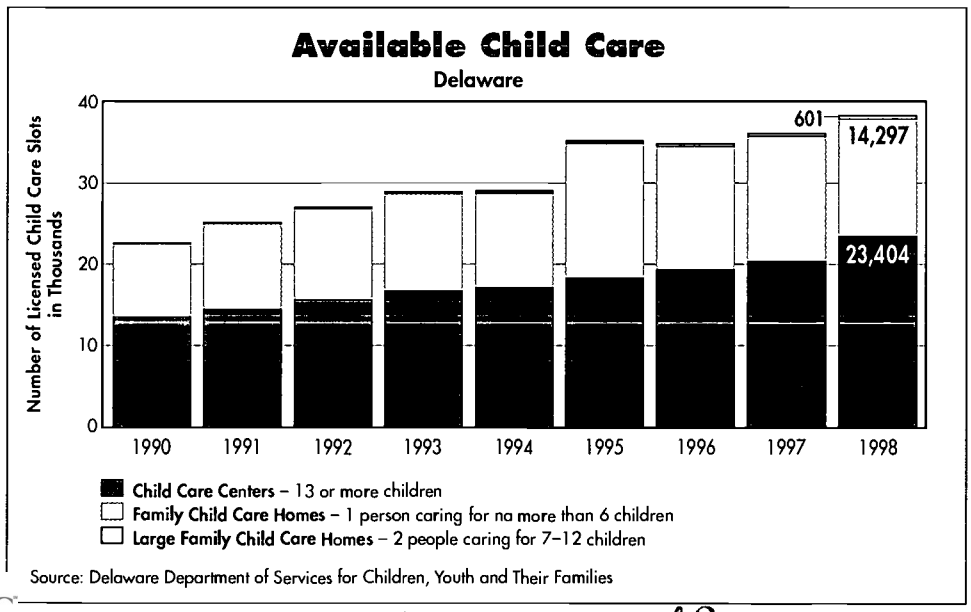




Availability: The increasing proportion of women in the labor force has resulted in significant numbers of children who need child care in their earliest years. Recent changes in welfare law requiring women to work or participate in work programs means additional children in need of quality child care. Research points to a relatively low supply of quality child care for infants, school-age children, children with disabilities and special health care needs, and families with unconventional or shifting work hours [1]. The problems and temptations that school-age children face when they are left unsupervised are alarming. Studies indicate that children who are left unsupervised have higher absentee rates at school, have lower academic test scores, exhibit higher levels of fear, stress, nightmares, loneliness, and boredom, are 1.7 times more likely to use alcohol, and are 1.6 times more likely to smoke cigarettes [2].

1 *Early childhood care and education: An investment that works.* (1995). Washington, DC: National Conference of State Legislatures.

2 Growing up with someplace to go: providing care for school are children. Available: http://www.ci.seattle.wa/most/grownup.htm/



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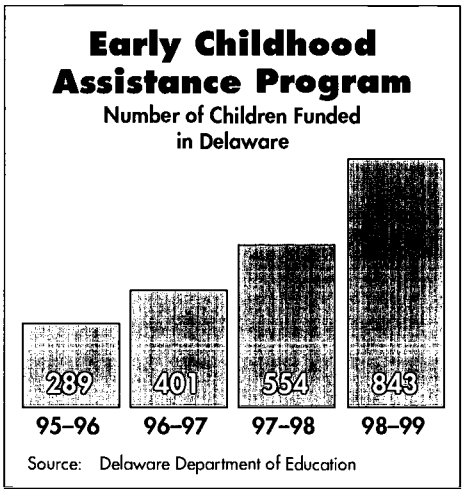
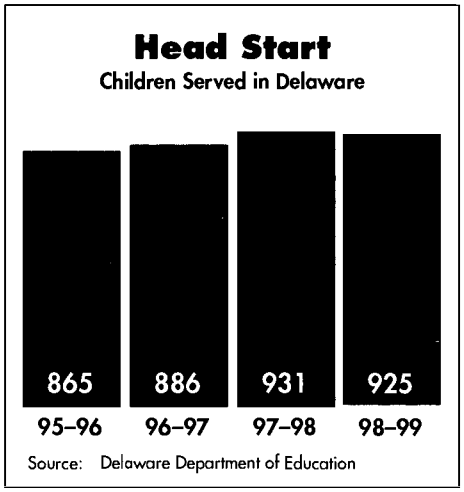
Head Start/ECAP: Head Start is a comprehensive early childhood development program for low-income preschool children and their families. The Early Childhood Assistance Program in Delaware provides funding for four-year olds who meet the eligibility criteria for Head Start programs. Both programs are designed to provide low-income children with the socialization and school readiness skills they need to enter public schools on an equal footing with more economically advantaged children[1].

1 Children's Defense Fund. (1995). The State of America's Children Yearbook: 1995. Washington, D.C.





School Age Care: The problems and temptations that school age children face when they are left unsupervised are alarming. Studies indicate that children who are left unsupervised have higher absentee rates at school, have lower academic test scores, exhibit higher levels of fear, stress, nightmares, loneliness, and boredom, are 1.7 times more likely to use alcohol, and are 1.6 times more likely to smoke cigarettes[1]. High quality after school programs, staffed by trained, caring adults, can have a measurably positive effect on children. These types of programs can help meet the critical child care needs of working families and their children. Programs based in schools are highly desirable for a number of reasons. Schools exist in every community and offer valuable resources that could be utilized to provide after school programs. And because children are already at school, there is no transportation needed in the middle of the day[2].

1 Growing up with someplace to go: providing care for school age children. Available: http://www.ci.seattle.wa.us/most/growup.htm/

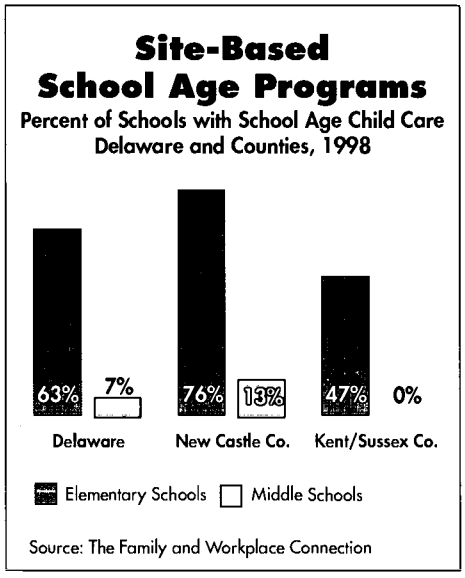
2 National PTA. (1998, April). Before- and after- school care.

Child Care and School Age Programs

Delaware and Counties, 1998

	Total	School Age
Delaware	2,023	1,721
New Castle Co.	1,241	1,001
Kent/Sussex Co.	782	720

Source: The Family and Workplace Connection



For more information see

Table 48 p. K-78

Tables 62-65 p. K-84-85

In the FAMILIES COUNT Section:

y Intervention p. F-26

d Start p. F-27

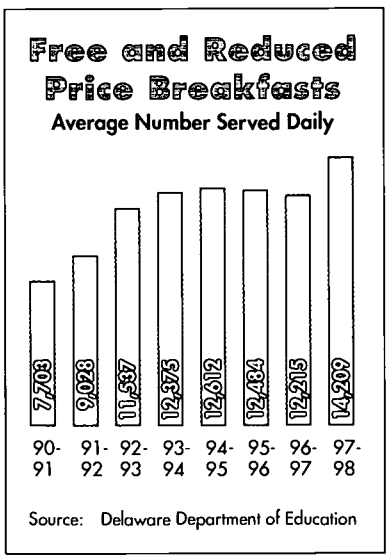
Children Receiving Free and Reduced Price School Meals

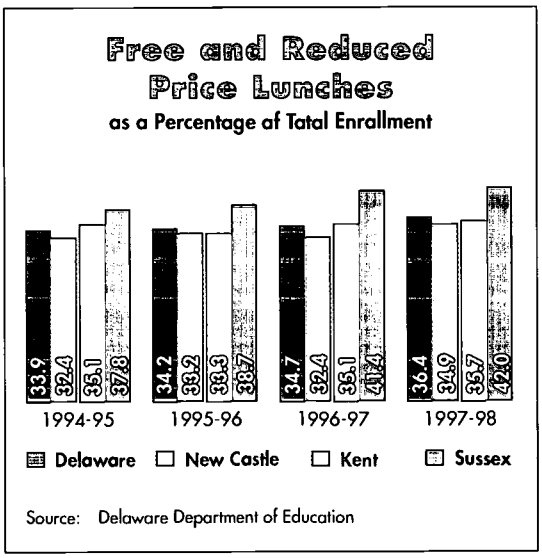
Research has consistently shown a relationship between poverty, poor nutrition, and educational development in children. The Food Research and Action Center reports that hungry children are inattentive in class, likely to have discipline problems, and perform poorly in problem-solving activities[1].

Children who have adequate nourishment are more active and social on the playground, more focused in class, and better able to think and remember what they have learned. When children do not master academic skills and fall behind in school, their chances to develop their potential as students, lifelong learners, and productive members of society decrease.

1 Action Alliance for Children. (1997, November-December). Healthy meals = healthy kids. Available <http://www.4children.org>.

The National School Lunch and School Breakfast Programs provide nutritious meals to children at participating schools. To receive a reduced-price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall below 130% of poverty. Children in Food Stamp and Medicaid households are automatically eligible for free meals. Participation levels in this program, however, are affected by a variety of factors such as the level of outreach in the school community and the extent to which children are stigmatized as participants. Although not every eligible student participates, the number of children receiving free or reduced-price meals can indicate the number of low-income children in a school district.





High expenses, illness, disability, or unemployment can diminish a family's food supply. The cause is not always poverty. 12% of the people in the United States do not have access to sufficient food on a regular basis.

Source: Hunger in New York State, *Human Ecology Forum*, Winter 1999 v27 pg8

The number of children who actually experience hunger themselves, even though they may live in a food-insecure household where one of more family members experience hunger, is believed to be significantly smaller than the total number of children living in such households. This is because in most such households the adults go without food, if necessary, so that the children will have food.

Source: *On the Table.* U.S. Department of Agriculture. Washington, DC.

For more information see

Children in Poverty	p. K-34
Women and Children Receiving WIC	p. K-42
Health Problems of Low-income Children	p. K-35
Tables 49-50	p. K-79

In the FAMILIES COUNT Section:

Children in Poverty	p. F-34

Women and Children Receiving WIC

While welfare reform initiatives nationwide have emphasized eliminating many former entitlement programs, federal food assistance programs, including WIC, were retained as a nutritional safety net. Assisting in "achieved nutritional security," WIC contributes to improved diet quality and quantity for members of low-income households[1]. In addition to increasing the average birth weight by 91 grams, WIC also improves children's health by increasing immunization rates[2].

1 Basiotis, P. P., Kramer-LeBlanc, C. S., Kennedy, E. T. (1998, Winter). Maintaining nutrition security and diet quality: The role of the food stamp program and WIC. *Family Economics and Nutrition Review*. 4.

2 Ku, L. (1999, Spring). Debating WIC. *The Public Interest*. 35, 108.

WIC Program

Average Number Served per Month Delaware, 1996 and 1998*

	1996	1998
Infants	4,414	4,430
Children 1–4	8,353	7,756
Mothers	3,230	3,449

*Federal Fiscal Years
Source: Division of Public Health, WIC Office

WIC Program

Total Number Served Delaware, 1998

In federal fiscal year 1998, approximately 19,052 infants and children were served by WIC in the State of Delaware.

Over 40% of all infants born in 1998 in Delaware used the services of WIC in that year.

Source: Division of Public Health, WIC Office

Of infants who received WIC preceding their first birthday, 82.4% continued to receive WIC after their first birthday.

Long-term WIC participation is uncommon. Only one-quarter of infants and children who ever receive WIC stay on until their fifth birthday.

Source: *On the Table*. U.S. Department of Agriculture. Washington, DC.

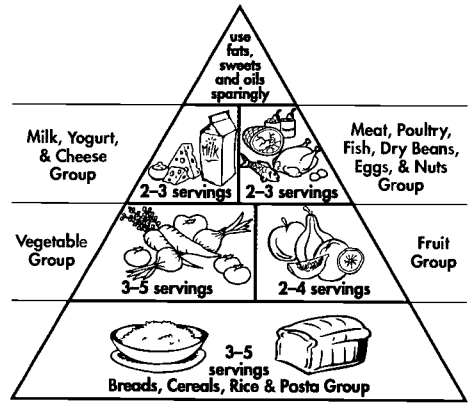
WIC families get monthly supplies of foods high in **protein, iron, vitamin C, and calcium.**

Participants receive vouchers for milk, cereals, eggs, cheese, peanut butter, beans, juices, and infant formula. Breast feeding moms also receive tuna and carrots.

Women who are pregnant or breastfeeding need to increase their servings to four to five servings from the Milk, Yogurt, and Cheese Group.

Source: WIC Growing Healthy Families, www.boca.co.gov

The Food Guide Pyramid



For more information see

Children in Poverty	p. K-34
Children Receiving Free and Reduced Price School Meals	p. K-41
Health Problems in Low-income Children	p. K-35
Table 49-50	p. K-79
Table 58	p. K-82

FAMILIES COUNT Section:

Children in Poverty	p. F-34

Asthma

Asthma is one of the most common chronic conditions affecting children. Despite major advances in treatment, morbidity and mortality rates in pediatric asthma have risen over the past two decades. These increases have disproportionately affected children living in poverty. Inadequately controlled asthma often has negative effects on the quality of life of children and their families and may result in the failure of children to reach their full potential as adults. School and job attendance, school performance, participation in physical activities, peer group and family relationships, and behavioral and emotional development may all suffer due to this condition. Asthma is also a major contributor to health care costs for children and adults.

Definition:

Readmissions – Number of asthma inpatient haspital admissians far children 0–17 wha had previausly been discharged with a diagnasis af asthma in the same year

Discharge Rate – Number of inpatient asthma discharges far children 0-17 per 1,000 children in the same age graup

Readmission Rate – Number af inpatient asthma readmissians far children 0-17 per 100 children previausly admitted in the same year

Hospitalizations for Childhood Asthma

Inpatient Asthma Discharges for Children 0–17 Years of Age by Health Insurance Status, Delaware Hospitals, 1995 and 1996

	Children Discharged		Readmissions		Total Discharges		Discharge Rate		Readmission Rate	
	1995	1996	1995	1996	1995	1996	1995	1996	1995	1996
Delaware	570	485	104	77	674	562	3.9	3.2	18.2	15.9
Medicaid	278	268	69	59	347	327	6.4+	7.4+	24.8+	22.0+
Non-Medicaid	292	217	35	18	327	235	2.9	1.8	12.0	8.3

Nate: + indicates that the Medicaid rate is statistically higher than the Nan-Medicaid rate
Saurce: Delaware Health Statistics Center

Hospitalization rates are one measure of morbidity associated childhood asthma. The table above compares 1995 and 1996 Delaware hospitalization data for childhood asthma. Although total asthma hospitalizations, hospitalization rate and readmission rate for children at Delaware hospitals declined in 1996, these improvements were almost entirely attributable to changes in the non-Medicaid population. In 1996, children hospitalized for asthma were more than four times as likely to be Medicaid eligible. Also in 1996, children rehospitalized for asthma within the same year were over twice as likely to be Medicaid eligible.

These data indicate that in 1996 Delaware Medicaid children continued to suffer excess asthma morbidity as measured by the need for hospitalization, and that the gap between Medicaid versus non-Medicaid children appeared to be widening over this two-year period. Several factors have been implicated in contributing to this problem, including health care access barriers associated with poverty, lack of patient/family knowledge about the condition and its management, and environmental asthma "triggers" such as the recently recognized role of cockroach antigen exposure in increasing the severity of asthma among low-income inner-city children.

Asthma experts believe that the majority of childhood asthma hospitalizations, as well as other morbidity associated with the condition could be prevented with appropriate management of the disease, including patient/family education, medications, and environmental control. KIDS COUNT in Delaware will continue to follow this indicator of childhood asthma morbidity, with particular interest in the possible impact of Medicaid managed care, child health insurance coverage expansion programs and other health care reform initiatives in Delaware.

For more information see

Child Deaths	p. K-24
Health Problems in Law-incame Children	p. K-35
Children withaut Health Insurance	p. K-44
Tables 51-52	p. K-80

In the FAMILIES COUNT Section:

Child Deaths	p. F-18
Health Care Caverage (Children)	p. F-19
Health Care Caverage (Families)	p. F-41

Children without Health Insurance

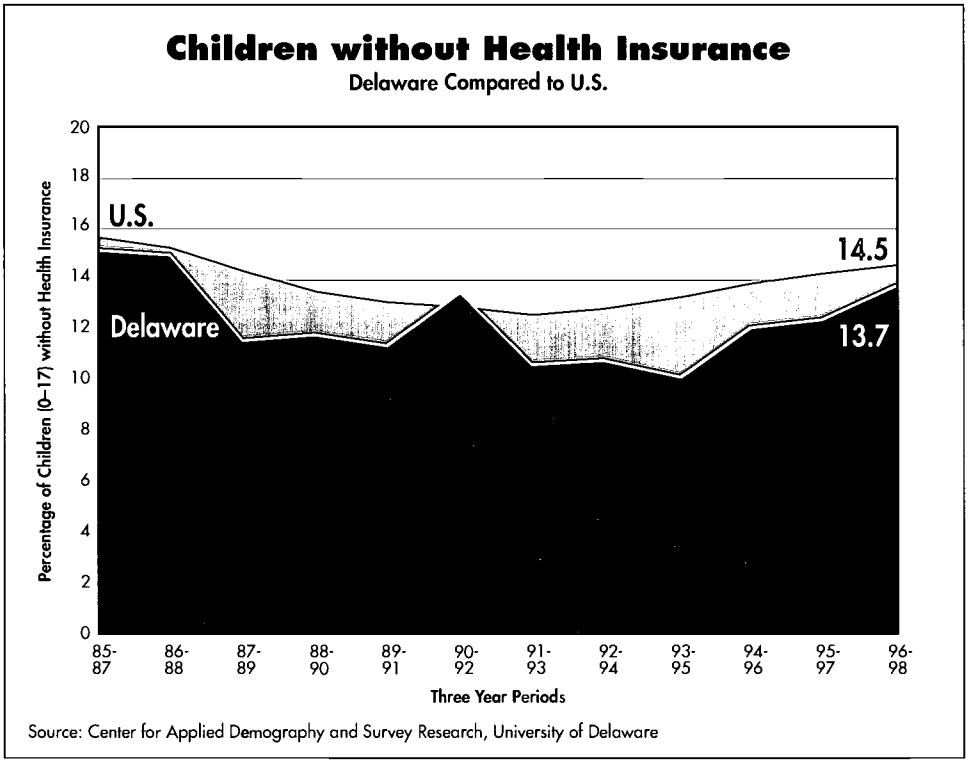
Children who do not have health insurance are much less likely to be taken to a doctor when they appear sick than children who do have health insurance.[1] Lack of health insurance decreases the likelihood that a child will have a single primary care physician and when children are under three, increases the risk that they are not being vaccinated or screened for developmental disorders.[2] Additionally, uninsured children are likely to use hospital emergency rooms for care with conditions that could have been easily treated or prevented at a fraction of the cost.[3]

In Delaware, the Delaware Healthy Children Program was created with funds from the Balanced Budget Act of 1997. Beginning in January 1999, the plan allows every uninsured child with a family income below 200% poverty to obtain a high quality, low cost health care policy. Approximately 10,500 Delaware children are eligible to benefit from this new program.

1 Federal Interagency Forum on Child and Family Statistics. (1999). *America's Children: Key National Indicators of Well-Being.*

2 Kogan, M. D., Alexander, G. R., Treitelbaum, M. A., Jack, B. W., Kotelchuck, M., Pappas, G. (1995, November 8). The effects of gaps in health insurance on continuity of a regular source of care among preschool-aged children in the United States. *The Journal of the American Medical Association, 274* (18), 1429-1435.

3 Leif, L. (1997, April 28). Kids at risk: uninsured children increasingly come from middle-class families. *U.S. News and World Report 122* (16), 66-69.



Source: Center for Applied Demography and Survey Research, University of Delaware

Delaware Healthy Children Program

Applications and Enrollment through July 31, 1999

Applications mailed to families	3,622
Total enrolled ever	**3,125**
Total currently enrolled	1,939

*** Please note that a number of children were discovered to be eligible for Medicaid through the application process (approximately 650 children as of June 30, 1999).**

Disenrollments due to non-payment of premiums have been a problem, especially for children transitioning straight from Medicaid.

Some of the steps the Department of Health and Social Services is taking to reduce disenrollments include:

- reviewing procedures for explaining the transition to families and working to ensure that notices are sent automatically.
- attempting to contact all disenrolled families. As of the end of July, 172 children had been re-enrolled.
- implementing the next phase of a publicity and outreach campaign consisting of television, radio, billboard and transit sign outreach.

Plans are in place for the Health Benefits Manager to send brochures home with every school child. The Division of Social Services sent the DHCP information card to all Delaware households during August–September. Plans for the Covering Kids (Robert Wood Johnson) grassroots outreach programs are well underway, with implementation scheduled for September.

That a child's health varies by family income? As family income increases, the percentage of children in very good or excellent health increases. In 1996, about 65% of children in families **below the poverty** were in very good or excellent health, compared with 84% of children living **at or above** the poverty line.

The proportion of children covered by **private health insurance** decreased from 74% in 1987 to 67% in 1997. During the same period, the proportion of children covered by **public health insurance** grew from 19% to 23%.

For more information see

Child Deaths	p. K-24
Children in Poverty	p. K-34
Health Problems in Low-income Children	p. K-35
Asthma	p. K-43
Tables 20-23	p. K-66-67
Tables 51-52	p. K-66-67
In the FAMILIES COUNT Section:	
Child Immunizations	p. F-17
Child Deaths	p. F-18
Health Care Coverage (Children)	p. F-19
Health Care Coverage (Families)	p. F-41

Alcohol, Tobacco, and Other Drugs

Research shows that alcohol is the drug most frequently used by 12–17 year olds and that alcohol-related car crashes are the number one killer of teens. Its use is associated not only with motor vehicle crashes but also with other injuries, deaths, problems in school, fighting, crime, and other serious consequences. [1]

Smoking has serious long-term consequences, including the risk of smoking related diseases, increased health care costs associated with treating these illnesses and the risk of premature death. [2] *Many adults who are addicted to tobacco today began smoking as adolescents, and it's estimated that more than 5 million of today's underage smokers will die of tobacco-related illnesses.* [3]

Drug use by adolescents can have immediate as well as long-term health and social consequences. Marijuana use poses both health and cognitive risks while cocaine is linked with health problems such as eating disorders and death from heart attacks and strokes. Possession and/or use of drugs is illegal and can lead to a variety of penalties and a permanent criminal record. [1]

1 America's Children: Key National Indicators of Well-Being, 1999.

2 Kessler, D.A. et al. (1996). The Food and Drug Administration's regulation of tobacco products. *New England Journal of Medicine*, 335 (13), 988-994.

3 Centers for Disease Control and Prevention. (1996). Projected smoking-related deaths among youth-United States. *Morbidity and Mortality Weekly Report*, 45 (44), 971-974.

86% of kids who smoke prefer Marlboro, Camel and Newport— the three **most heavily advertised** brands. Marlboro, the most heavily advertised brand, constitutes almost 60% of the youth market but only **25%** of the adult market.

Almost 90% of adult smokers began at or **before age 18.**

The **younger** the individual uses tobacco, the **more likely** that individual is to experiment with **cocaine, heroin or other illicit drugs.**

Source: Campaign for Tobacco-Free Kids, www.tobaccofreekids.org

97% of 5th graders ,
91% of 8th graders, and
85% of 11th graders report having some drug education in school.
(DARE is part of the 5th grade curriculum statewide.)

Binge drinking is quite high among **8th** and **11th** graders. Most students who report having at least one drink in the past month also report binge drinking in the past 2 weeks.

28% **of all 11th graders report binge drinking** as well. Binge drinking is defined as three or more drinks at a time in the past two weeks.

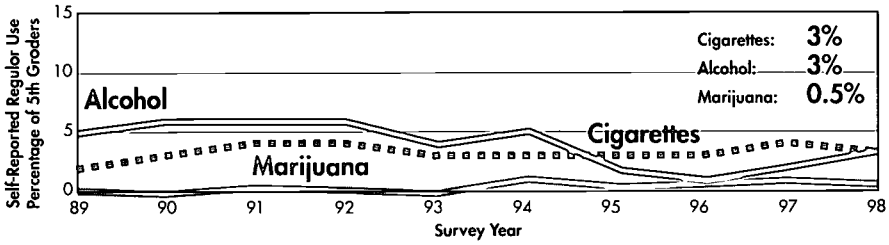
Source: Alcohol, Tobacco, and Other Drug Abuse Among Delaware Students, 1998, The Center for Drug and Alcohol Studies and The Center for Community Development and Family Policy, University of Delaware

Inhalant abuse, also referred to as huffing, sniffing, or solvent abuse, involves the use of common products that are most often found in the home, office, and classroom. **Inhalant abuse is on the rise** and has nearly doubled in the last decade. **Reasons** why children use inhalants: Low cost; way to rebel against parents; easy to get and hide; peer pressure or influence; not illegal to possess so kids can make excuses if they are caught with inhalants.

Source: American Academy of Pediatrics, www.aap.org, Inhalant Abuse: Your Child and Drugs.

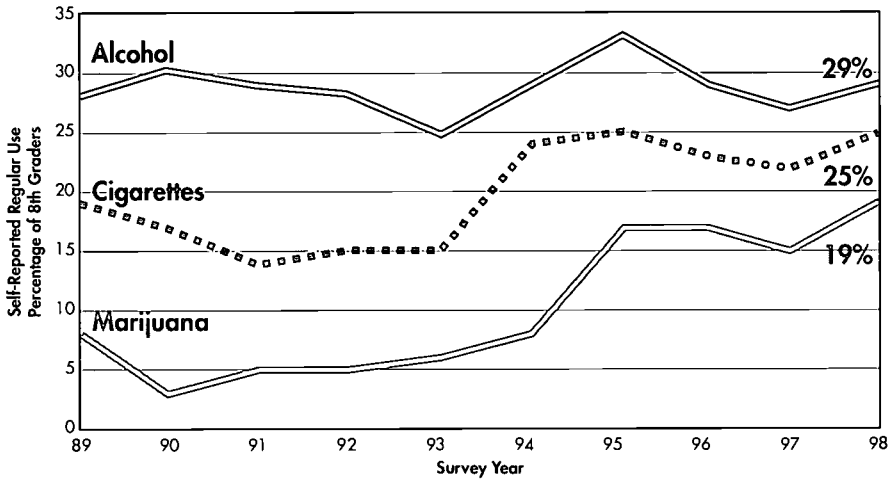
Trends in Cigarette, Alcohol, and Marijuana Use

5th Graders, Delaware 1989–1998



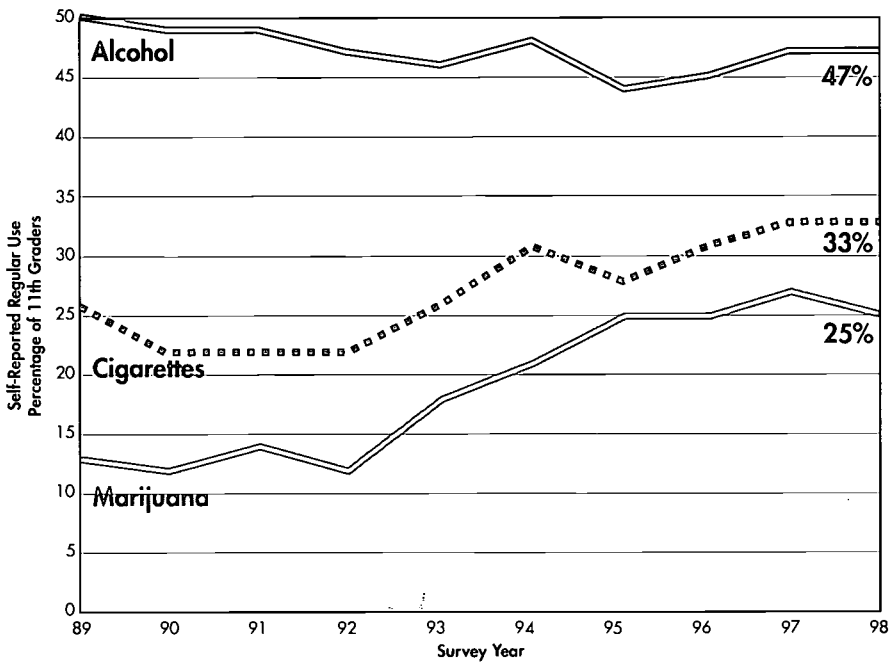
Trends in Cigarette, Alcohol, and Marijuana Use

8th Graders, Delaware 1989–1998



Trends in Cigarette, Alcohol, and Marijuana Use

11th Graders, Delaware 1989–1998



For more information see

Student Violence and Possession p. K-33

Tables 30-36 p. K-70-73

In the FAMILIES COUNT Section:

Substance Abuse p. F-20-21

Child Abuse and Neglect

Child abuse and neglect can have devastating and long-lasting effects. It takes an enormous emotional toll on its victims and, if untreated, may lead to continuing the cycle as the victim becomes an adult abuser.[1] Preventing child abuse and neglect is critical to helping children grow into strong, healthy, productive adults and good parents. Nationally in 1997, more than half of all victims suffered neglect; almost a quarter suffered physical abuse. Twelve percent were sexually abused, while victims of psychological abuse, medical neglect, and "other" types of maltreatment accounted for less than 11 percent each.[2] Recent studies confirm that child abuse is linked to increases in dropout rates, juvenile delinquency, running away, substance abuse, suicide, criminal behavior, emotional disturbances, promiscuity and teenage pregnancy.[3]

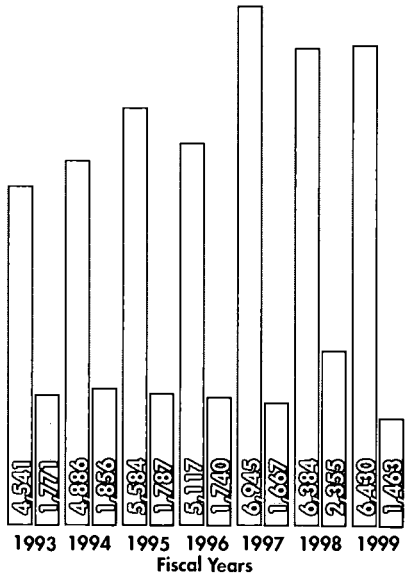
1 Child Abuse and Neglect. (1999). Tennessee Kids Count, *The State of the Child in Tennessee, 1999*

2 U.S. Department of Health and Human Services, Administration for Children & Families, Administration on Children, Youth and Families, 1999, *Child Maltreatment 1997: Reports from the States to the National Child Abuse and Neglect Data System.*

3 Child Abuse. (1999). Rhode Island Kids Count, *1999 Databook*

Child Abuse and Neglect

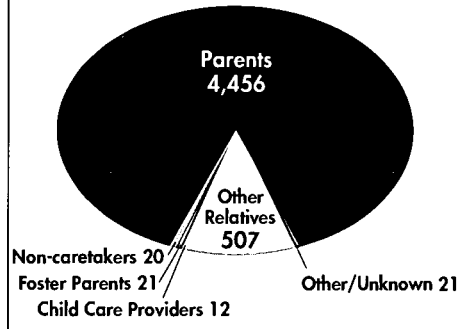
Accepted Reports & Substantiated Cases
Delaware, 1993–1999



Source: Department of Services for Children, Youth and Their Families

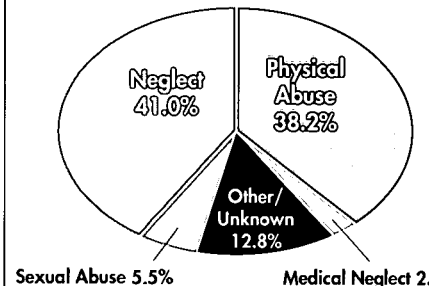
Who Are the Perpetrators

Delaware, 1997



Victims by Maltreatment*

Delaware, 1997



* Accepted reports and substantiated cases

Sources: U.S. Department of Health and Human Services; Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, National Center on Child Abuse and Neglect

For more information see

Child Deaths	p. K-24
Table 21	p. K-66
Table 23	p. K-67
Table 66	p. K-86

In the FAMILIES COUNT Section:

Child Deaths	p. F-18
d Abuse	p. F-44
estic Violence	p. F-47

Foster Care

Children who enter the foster care system bring with them many special needs. Often they are victims of physical abuse, sexual abuse, or neglect. They may also suffer from emotional, behavioral, or developmental problems.[1] Foster care is intended to improve the well being of he child on a short-term basis until family difficulties are resolved or until long-term alternatives can be found. Unfortunately, many children in foster care experience multiple placements or move from one home to another. Such moves often mean a change in caretaker, environment, and schools.[2]

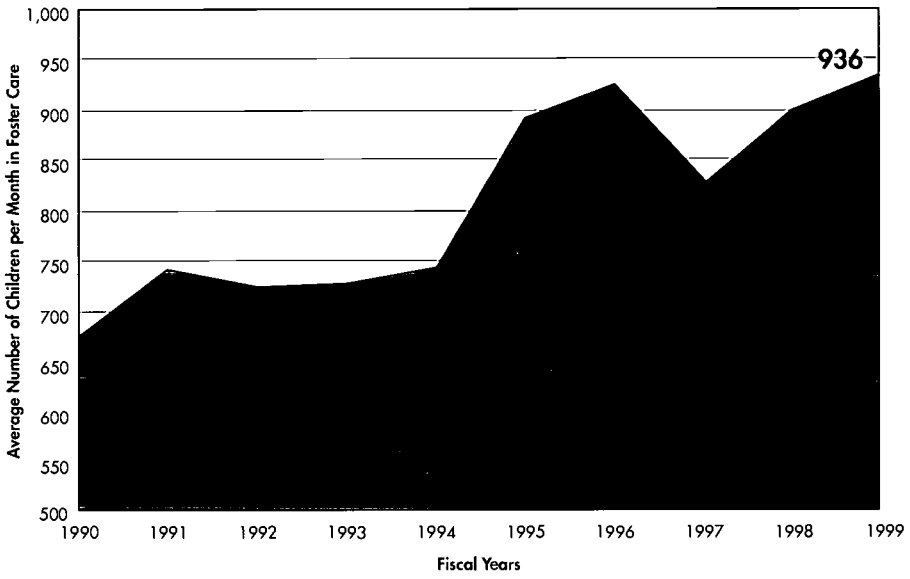
Infants and young children with medical complications, physical handicaps or mental limitations represent the fastest growing population in need of foster care.[1]

1 David and Lucille Packard Foundation and Annie E. Casey Foundation. (1997). Current Issues in foster care. *Take this Heart.*

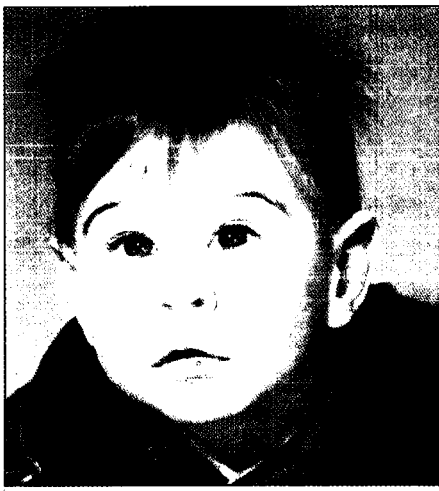
2 Out of Home Care. (1998). Kids Count in Nebraska, Suspensions and Expulsions.

Foster Care

Delaware



Source: Delaware Department of Services for Children, Youth and Their Families, Division of Family Services



Delaware needs more foster parents. The number of foster homes is not increasing at the same rate as the number of children who need them.

To be a Delaware foster parent, you must

- Be a Delaware resident and at least 21 years old.
- Complete 27 hours of training over a nine-week period.
- Supply references, undergo a criminal background check, and provide fingerprints.
- Be in good physical health and have sufficient income.
- Have a home health and safety check.

Delaware foster parents receive

- Monthly payments ranging from $415 to $576.
- Monthly clothing allowance for foster children ranging from $45 to $97.
- Medical/dental and mental health services provided for the child.

Source: Wilmington News Journal, June 28, 1999

For more information see

Child Abuse and Neglect p. K-48

In the FAMILIES COUNT Section:

Out-of-Home Care p. F-45

Juvenile Delinquents in Out-of-Home Care p. F-46

Data Tables

Table 1:

Population Estimates

Population Estimates for Delaware, Counties, Wilmington, Newark, and Dover, 1997

	0-4	5-9	10-14	15-19	20-64	65+	Total	% 0-19	% 20-64	% 65+	% Total
Delaware	51,453	50,203	50,040	49,406	455,344	94,740	751,186	26.8	60.6	12.6	100.0
Male	26,577	25,977	25,637	24,993	225,923	39,981	369,088	13.7	30.1	5.3	49.1
White	20,120	20,196	19,981	18,866	184,780	35,805	299,748	10.5	24.6	4.8	39.9
Black	5,775	5,087	5,193	5,799	36,800	3,868	62,522	2.9	4.9	0.5	8.3
Female	24,876	24,226	24,403	24,413	229,421	54,759	382,098	13.0	30.5	7.3	50.9
White	18,644	18,468	18,794	18,269	183,862	48,401	306,438	9.9	24.5	6.4	40.8
Black	5,568	5,056	5,090	5,741	40,853	5,939	68,247	2.9	5.4	0.8	9.1
New Castle	32,984	32,217	31,916	31,362	304,132	53,981	486,592	17.1	40.5	7.2	64.8
Male	17,110	16,812	16,452	15,832	150,924	22,059	239,189	8.8	20.1	2.9	31.8
White	13,010	12,983	12,815	11,908	122,640	19,650	193,006	6.8	16.3	2.6	25.7
Black	3,562	3,222	3,264	3,692	24,965	2,242	40,947	1.8	3.3	0.3	5.5
Female	15,874	15,405	15,464	15,530	153,208	31,922	247,403	8.3	20.4	4.2	32.9
White	12,022	11,782	11,938	11,529	122,472	28,086	197,829	6.3	16.3	3.7	26.3
Black	3,330	3,011	3,115	3,747	27,463	3,632	44,298	1.8	3.7	0.5	5.9
Newark**	1,049	1,053	1,187	5,432	17,338	2,399	28,458	1.2	2.3	0.3	3.8
Male	546	544	608	2,378	8,634	921	13,631	0.5	1.1	0.1	1.8
Female	503	509	579	3,054	8,704	1,478	14,827	0.6	1.2	0.2	2.0
Wilmington*	4,869	5,066	5,106	4,209	42,618	10,714	72,582	2.6	5.7	1.4	9.7
Male	2,471	2,664	2,639	2,214	20,441	3,764	34,193	1.3	2.7	0.5	4.6
White	663	669	618	546	9,613	2,396	14,505	0.3	1.3	0.3	1.9
Black	1,612	1,752	1,775	1,471	9,682	1,304	17,596	0.9	1.3	0.2	2.3
Female	2,398	2,402	2,467	1,995	22,177	6,950	38,389	1.2	3.0	0.9	5.1
White	692	612	548	474	9,242	4,771	16,339	0.3	1.2	0.6	2.2
Black	1,508	1,568	1,720	1,356	11,950	2,109	20,211	0.8	1.6	0.3	2.7
Kent	9,184	9,407	9,229	8,541	74,479	14,239	125,079	4.8	9.9	1.9	16.7
Male	4,714	4,804	4,656	4,349	36,808	6,161	61,492	2.5	4.9	0.8	8.2
White	3,490	3,708	3,557	3,266	29,817	5,325	49,163	1.9	4.0	0.7	6.5
Black	1,142	1,054	1,053	1,027	6,433	749	11,458	0.6	0.9	0.1	1.5
Female	4,470	4,603	4,573	4,192	37,671	8,078	63,587	2.4	5.0	1.1	8.5
White	3,255	3,447	3,445	3,182	29,285	6,949	49,563	1.8	3.9	0.9	6.6
Black	1,130	1,108	1,073	941	7,397	996	12,645	0.6	1.0	0.1	1.7
Dover**	1,872	1,966	1,966	2,645	18,399	3,506	30,354	1.1	2.4	0.5	4.0
Male	962	991	999	1,330	9,093	1,342	14,717	0.6	1.2	0.2	2.0
Female	910	975	967	1,315	9,306	2,164	15,637	0.6	1.2	0.3	2.1
Sussex	9,285	8,579	8,895	9,503	76,733	26,520	139,515	4.8	10.2	3.5	18.6
Male	4,753	4,361	4,529	4,812	38,191	11,761	68,407	2.5	5.1	1.6	9.1
White	3,620	3,505	3,609	3,692	32,323	10,830	57,579	1.9	4.3	1.4	7.7
Black	1,071	811	876	1,080	5,402	877	10,117	0.5	0.7	0.1	1.3
Female	4,532	4,218	4,366	4,691	38,542	14,759	71,108	2.4	5.1	2.0	9.5
White	3,367	3,239	3,411	3,558	32,105	13,366	59,046	1.8	4.3	1.8	7.9
Black	1,108	937	902	1,053	5,993	1,311	11,304	0.5	0.8	0.2	1.5

Racial breakdown may not total gender breakdown due to amission of "Other" races.
* Race estimates for the city of Wilmington are illustrative and should be interpreted with care.
** Race estimates not available for the cities of Newark and Dover.
Source: Delaware Population Consortium

Table 2:

Delaware Children and Their Families

Number and Percent of Children in Families, Delaware and Counties, 1990 Census

	Delaware		New Castle		Kent		Sussex	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total children under 18	**146,816**	**100.0**	**95,532**	**65.1**	**27,268**	**18.6**	**24,016**	**16.3**
In married-couple family:								
Under 3 years	21,188	14.4	14,099	14.8	3,929	14.4	3,160	13.2
3 and 4 years	13,924	9.5	9,081	9.5	2,717	10.0	2,126	8.9
5 years	6,931	4.7	4,388	4.6	1,275	4.7	1,268	5.3
6 to 11 years	39,580	27.0	25,831	27.0	7,117	26.1	6,632	27.6
12 and 13 years	11,944	8.1	7,713	8.1	2,307	8.5	1,924	8.0
14 years	5,764	3.9	3,645	3.8	1,136	4.2	983	4.1
15 to 17 years	16,687	11.4	10,826	11.3	3,165	11.6	2,696	11.2
Total	**116,018**	**79.0**	**75,583**	**79.1**	**21,646**	**79.4**	**18,789**	**78.2**
In other family:								
Male head of household, no spouse: (18.1% of children in single-parent families)								
Under 3 years	931	0.6	621	0.7	134	0.5	176	0.7
3 and 4	632	0.4	418	0.4	106	0.4	108	0.4
5 years	307	0.2	151	0.2	71	0.3	85	0.4
6 to 11 years	1,978	1.3	1,304	1.4	226	0.8	448	1.9
12 and 13 years	507	0.3	349	0.4	59	0.2	99	0.4
14 years	276	0.2	137	0.1	31	0.1	108	0.4
15 to 17 years	937	0.6	612	0.6	116	0.4	209	0.9
Total	**5,568**	**3.8**	**3,592**	**3.8**	**743**	**2.7**	**1,233**	**5.1**
Female head of household, no spouse: (81.9% of children in single-parent families)								
Under 3 years	3,052	2.1	1,893	2.0	652	2.4	507	2.1
3 and 4 years	2,744	1.9	1,612	1.7	625	2.3	507	2.1
5 years	1,444	1.0	899	0.9	320	1.2	225	0.9
6 to 11 years	9,266	6.3	6,025	6.3	1,879	6.9	1,362	5.7
12 and 13 years	3,004	2.0	2,066	2.2	456	1.7	482	2.0
14 years	1,486	1.0	932	1.0	256	0.9	298	1.2
15 to 17 years	4,234	2.9	2,930	3.1	691	2.5	613	2.6
Total	**25,230**	**17.2**	**16,357**	**17.1**	**4,879**	**17.9**	**3,994**	**16.6**

Source: Delaware Economic Development Office; U.S. Bureau of the Census

Table 3:

Number and Percent of Families with Children

Number and Percent of Families With Related Children Under 18 Years of Age
Delaware and Counties, 1990 Census

Type of Family	Delaware		New Castle		Kent		Sussex	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
One-Parent	21,708	24.3	14,252	24.3	3,807	23.6	3,649	25.0
Male Head of Household	4,083	4.6	2,627	4.5	614	3.8	842	5.8
Female Head of Household	17,625	19.7	11,625	19.8	3,193	19.8	2,807	19.2
Married Couple	67,642	75.7	44,375	75.7	12,317	76.4	10,950	75.0
Total	89,350	100.0	58,627	100.0	16,124	100.0	14,599	100.0

Source: Delaware Health Statistics Center; U.S. Bureau of the Census

Table 4:

Teen Birth Rates

Five-Year Average Live Birth Rates (births per 1,000) for Females Ages 15–19 by Race U.S., Delaware, and Counties, 1982–1997

Area/Race	1982-1986	1983-1987	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	51.1	50.7	51.0	52.4	54.1	56.4	58.5	59.9	60.2	59.6	58.0	56.3
White	42.8	42.2	42.2	43.3	44.9	47.1	49.2	50.8	51.5	51.4	50.4	49.3
Black	97.0	97.9	100.1	103.2	106.2	109.5	111.8	112.1	110.7	107.2	101.9	97.0
Delaware	48.6	48.5	48.7	50.7	52.0	53.9	55.0	55.9	56.6	57.4	57.7	58.1
White	33.8	33.5	33.8	34.9	35.7	36.7	37.4	38.3	39.1	40.2	40.6	41.3
Black	110.0	110.3	109.0	114.3	116.8	121.0	121.6	120.5	118.7	115.9	113.9	113.1
New Castle	40.7	41.0	41.5	43.1	44.6	46.1	47.5	48.2	49.0	50.3	51.5	51.5
White	27.0	27.0	27.6	28.0	28.6	29.2	30.1	30.9	32.1	33.8	35.2	34.9
Black	106.0	106.8	105.9	112.3	116.5	120.4	121.6	118.6	114.2	109.8	107.9	107.0
Wilmington	N/A	N/A	N/A	N/A	N/A	137.4	143.4	148.3	149.7	152.6	155.3	157.6
White	N/A	N/A	N/A	N/A	N/A	123.5	125.0	134.2	136.0	137.7	146.8	143.7
Black	N/A	N/A	N/A	N/A	N/A	158.1	166.6	170.7	171.8	175.1	175.9	180.8
Kent	61.0	60.0	58.1	61.3	62.2	63.8	63.6	65.1	65.5	65.6	65.3	65.2
White	55.4	53.6	50.9	52.6	52.2	52.5	52.5	53.2	52.6	51.3	50.8	50.2
Black	80.7	82.0	81.5	88.6	92.3	96.6	94.4	98.5	101.7	106.1	107.6	112.0
Sussex	71.1	70.3	71.4	73.9	74.6	78.3	79.1	79.0	78.5	76.9	73.0	74.8
White	43.3	43.1	45.5	49.1	51.6	54.9	54.9	55.4	54.4	54.1	51.0	55.7
Black	159.0	157.5	155.0	155.8	151.4	156.4	157.9	155.2	155.2	148.0	140.7	135.2

Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 5:

Teen Birth Rates (15–17 year olds)

Five-Year Average Live Birth Rates (births per 1,000) for Females Ages 15–17 U.S., Delaware, and Counties, 1982–1997

Area/Race	1982-1986	1983-1987	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	31.3	31.2	31.6	32.6	33.8	35.5	36.8	37.7	37.9	37.6	36.6	35.5
Delaware	32.6	32.9	33.5	35.8	37.0	37.9	39.6	40.4	42.2	43.7	44.8	43.8
New Castle	29.7	30.7	31.0	33.1	34.2	35.5	37.4	38.3	40.1	42.6	44.3	43.0
Kent	34.5	34.5	35.7	39.8	40.2	39.3	38.6	39.8	40.4	41.2	43.1	41.9
Sussex	41.9	39.7	40.7	42.1	43.9	45.3	49.0	48.7	51.3	49.9	47.9	48.0

Sources: Delaware Health Statistics Center; National Center for Health Statistics; Center for Applied Demography and Survey Research, University of Delaware

Table 6:

Pre- and Young Teen Birth Rates (10–14 year olds)

Five-Year Average Live Birth Rates (births per 1,000) for Females Ages 10–14 by Race U.S., Delaware, and Counties, 1982–1997

Area/Race	1982-1986	1983-1987	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	1.2	1.2	1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.3	1.3
White	0.6	0.6	0.6	0.6	0.7	0.7	0.7	0.8	0.8	0.8	0.8	0.8
Black	4.4	4.5	4.7	4.8	4.9	4.9	4.9	4.8	4.7	4.6	4.3	4.1
Delaware	1.8	1.8	1.8	1.8	1.8	1.9	2.0	2.1	2.1	2.2	2.2	2.0
White	0.5	0.6	0.6	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.8	0.8
Black	6.0	5.9	5.8	5.6	5.9	6.2	6.7	6.6	7.3	7.3	7.1	6.5
New Castle	1.7	1.7	1.7	1.6	1.7	1.9	2.1	2.1	2.2	2.2	2.2	1.9
White	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.8	0.7	0.7	0.7	0.6
Black	6.1	6.1	5.7	5.2	5.6	6.0	6.6	6.5	7.2	7.2	7.2	6.4
Kent	1.3	1.5	1.4	1.4	1.7	1.9	1.8	1.9	2.0	1.8	1.8	1.6
White	0.4	0.5	0.4	0.5	0.8	0.8	0.8	1.0	0.9	0.8	1.1	1.0
Black	4.7	5.0	5.1	4.7	4.9	5.9	5.4	5.3	5.7	5.1	4.3	3.8
Sussex	2.5	2.3	2.3	2.7	2.7	2.6	2.7	2.6	2.7	3.0	3.0	2.9
White	1.0	1.0	0.8	1.0	1.0	1.0	0.9	0.8	0.8	1.0	1.1	1.1
Black	6.6	6.0	6.5	7.7	7.9	7.4	8.1	8.4	9.4	10.0	9.5	9.5

Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 7:

Teen Mothers Who Are Single

Five Year Average Percentage of Births to Mothers Under 20 Years of Age Who Are Single U.S., Delaware, Counties, 1983–1997

Area/Race	1983-1987	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	58.9	61.3	63.5	65.3	66.9	68.1	69.3	71.0	72.6	74.0	N/A
White	45.2	48.2	51.0	53.4	55.5	57.3	59.0	61.4	63.7	65.7	N/A
Black	90.0	90.5	91.1	91.5	91.9	92.3	92.6	93.2	93.8	94.8	N/A
Delaware	69.0	70.5	73.1	74.7	76.7	79.4	81.8	84.6	86.7	88.3	89.1
White	49.7	53.0	56.2	58.6	61.2	65.2	69.3	73.8	77.3	80.2	81.5
Black	90.9	90.9	92.3	92.9	94.0	94.9	95.7	96.7	97.4	97.7	97.9
New Castle	74.3	74.9	77.8	79.4	81.4	84.1	86.4	88.8	90.6	91.6	92.5
White	57.4	59.1	62.6	65.3	68.2	72.3	76.5	80.6	83.4	85.2	86.5
Black	82.7	92.6	93.9	94.1	94.8	95.7	96.4	97.2	98.0	98.4	98.6
Kent	56.1	59.7	62.3	65.3	67.7	71.0	75.1	78.1	80.1	81.7	82.1
White	39.8	44.1	46.4	49.2	50.9	56.1	61.6	66.3	68.4	71.9	72.3
Black	85.9	86.6	88.1	90.4	92.6	94.0	95.7	96.8	97.7	97.1	96.9
Sussex	67.1	69.0	71.1	70.9	72.8	74.5	76.0	79.6	82.6	85.5	86.7
White	39.5	46.0	50.3	51.2	54.5	56.7	59.3	64.5	70.5	75.4	78.4
Black	90.0	89.4	90.8	91.3	92.6	93.1	93.7	95.1	95.6	96.1	96.8

Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 8:

Births by Race and Age of Mother

Number and Percent of Live Births by Race and Age of Mother Delaware, Counties and City of Wilmington, 1997

Area/Race	Total Births to All Ages	Births to Teen Mothers 19 years old and under		Births to Teen Mothers Less than 15 years old		Births to Teen Mothers 15–17 years old		Births to Teen Mothers 18–19 years old	
	Total Number	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Delaware	10,247	1,374	13.4	35	0.3	522	5.1	817	8.0
White	7,502	715	9.5	7	.09	260	3.5	448	6.0
Black	2,495	648	25.9	27	1.1	260	10.4	361	14.5
Other	250	11	4.4	1	0.4	2	0.8	8	3.2
New Castle	6,693	754	11.3	19	0.3	297	4.4	438	6.5
White	4,859	342	7.0	3	0.06	127	2.6	212	5.0
Black	1,644	408	24.8	15	0.9	170	10.3	223	13.6
Other	190	4	2.1	1	0.5	0	0.0	3	1.6
Wilmington	1,191	309	26.0	11	0.9	136	11.4	162	13.6
White	412	48	11.6	0	0.0	22	5.3	26	6.3
Black	767	260	33.9	10	1.3	114	14.8	136	17.7
Other	12	1	8.3	1	8.3	0	0.0	0	0.0
Balance of NC County	5,502	445	8.1	8	0.1	161	2.9	276	5.0
White	4,447	294	6.6	3	0.06	105	2.3	186	4.1
Black	877	148	16.8	5	0.05	56	6.3	87	9.9
Other	178	3	1.6	0	0.0	0	0.0	3	1.6
Kent	1,718	267	15.5	5	0.3	83	4.8	179	10.4
White	1,264	161	12.7	2	0.2	51	4.0	108	6.3
Black	411	101	24.6	3	0.7	31	7.5	67	16.3
Other	43	5	11.6	0	0.0	1	2.3	4	9.3
Sussex	1,836	353	19.2	11	0.6	142	7.7	200	10.8
White	1,379	212	15.3	2	0.1	82	5.9	128	9.3
Black	440	139	31.6	9	2.0	59	13.4	71	16.1
Other	17	2	11.7	0	0.0	1	5.8	1	5.8

1. Percentages may not add to 100% due to rounding.
2. Percentages are calculated based upon the total number of births in each race group for all ages.
3. Percentages for the race group "Other" may be misleading due to the small number of births in this category.

Source: Delaware Health Statistics Center

Table 9:

Percentage of Low Birth Weight Births

Five-Year Average Percentage of All Births that Are Low Birth Weight Births
U.S. and Delaware, 1983–1997

	1983-1987	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	6.8	6.8	6.9	6.9	7.0	7.0	7.1	7.1	7.2	7.2	7.3
Delaware	7.2	7.3	7.3	7.4	7.4	7.6	7.7	7.7	7.8	8.0	8.2
New Castle	N/A	7.3	7.4	7.5	7.6	7.8	8.0	8.0	8.2	8.3	8.5
Kent	N/A	7.0	7.1	7.1	7.1	7.3	7.2	7.0	7.3	7.2	7.5
Sussex	N/A	7.3	7.2	7.1	7.2	7.1	7.2	7.1	7.2	7.7	8.0

Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 10:

Low Birth Weight Births by Age and Race of Mother

Five-Year Average Percentage of Low Birth Weight Births by Age and Race of Mother
Delaware and Counties, 1990–1997

	1990–1994			1991–1995			1992–1996			1993–1997		
Area/Age	All Races	White	Black	All Races	White	Black	All Races	White	Black	All Races	White	Black
Delaware	7.7	5.9	13.5	7.8	6.1	13.4	8.0	6.3	13.3	8.2	6.5	13.5
Less than 20	10.5	8.0	13.4	10.7	8.3	13.4	10.7	8.1	13.7	10.6	7.9	13.7
20-24	7.7	5.4	12.5	7.9	5.5	12.8	8.3	6.0	13.1	8.5	6.3	13.0
25-29	6.6	5.1	12.8	6.8	5.5	12.5	7.0	5.8	12.0	7.2	5.9	13.1
30+	7.7	6.3	16.3	7.6	6.4	15.5	7.6	6.5	14.8	7.9	6.8	14.5
New Castle	8.0	6.0	14.6	8.2	6.2	14.3	8.3	6.4	14.3	8.5	6.6	14.3
Less than 20	11.4	8.8	14.1	11.5	9.0	14.0	11.4	8.8	14.1	11.2	8.4	13.9
20-24	8.5	5.8	13.5	8.5	5.7	13.6	9.2	6.4	14.3	9.4	6.8	14.4
25-29	7.0	5.3	14.3	7.2	5.6	13.8	7.1	5.6	13.1	7.4	5.7	14.3
30+	7.7	6.2	17.3	7.8	6.5	16.1	7.7	6.5	15.7	8.0	6.8	15.2
Kent	7.0	5.7	11.3	7.3	5.8	12.2	7.2	5.9	11.8	7.5	5.9	12.4
Less than 20	9.4	7.5	12.1	9.6	7.1	13.3	9.3	6.8	13.4	9.0	6.3	13.2
20-24	6.8	5.2	11.2	7.0	5.2	11.9	6.9	5.2	11.5	7.3	5.6	12.0
25-29	5.3	4.7	8.1	6.0	5.4	8.8	6.3	5.8	8.7	6.8	6.1	10.6
30+	8.1	6.7	15.0	7.7	6.1	15.9	7.5	6.2	14.0	7.5	5.9	14.1
Sussex	7.1	5.4	11.7	7.2	5.7	11.5	7.7	6.4	11.5	8.0	6.8	11.6
Less than 20	9.3	6.5	12.3	9.7	7.6	12.0	10.0	7.4	12.8	10.8	8.4	13.6
20-24	6.8	4.7	10.9	7.1	5.1	11.1	7.4	5.8	10.9	7.5	6.0	10.7
25-29	6.1	5.0	11.6	6.3	5.2	11.1	7.1	6.4	10.7	7.0	6.4	10.4
30+	7.1	6.2	12.5	6.8	6.0	12.1	7.1	6.4	11.4	7.8	7.2	11.3

Source: Delaware Health Statistics Center

Table 11:

Percentage of Very Low Birth Weight Births

Five-Year Average Percentage of All Births that Are Very Low Birth Weight Births U.S. and Delaware, 1984–1997

	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.3	1.3	1.3
Delaware	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.7

Note: Very Low Birth Weight (<1500 grams) is a subdivision of Low Birth Weight (<2500 grams).
Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 12:

Very Low Birth Weight Births by Age and Race of Mother

Five-Year Average Percentage of Very Low Birth Weight Births by Age and Race of Mother Delaware and Counties, 1990–1997

	1990–1994			1991–1995			1992–1996			1993–1997		
Area/Age	All Races	White	Black	All Races	White	Black	All Races	White	Black	All Races	White	Black
Delaware	1.6	1.0	3.4	1.6	1.1	3.2	1.6	1.1	3.2	1.7	1.2	3.3
Less than 20	2.4	1.6	3.3	2.4	1.7	3.2	2.3	1.6	3.1	2.2	1.4	3.1
20-24	1.6	0.9	3.1	1.6	1.0	2.9	1.7	1.1	3.1	1.8	1.2	3.2
25-29	1.3	0.9	3.2	1.4	1.0	3.0	1.4	1.1	3.0	1.5	1.1	3.3
30+	1.5	1.1	4.2	1.5	1.1	4.1	1.5	1.1	4.0	1.6	1.2	3.8
New Castle	1.7	1.1	3.8	1.7	1.1	3.6	1.7	1.1	3.8	1.8	1.2	3.6
Less than 20	2.8	1.9	3.6	2.5	1.8	3.2	2.5	1.6	3.3	2.2	1.3	3.0
20-24	1.9	1.0	3.4	1.8	1.1	3.2	2.1	1.2	3.7	2.0	1.2	3.6
25-29	1.4	0.8	3.8	1.5	1.0	3.5	1.5	1.1	3.5	1.6	1.1	3.8
30+	1.6	1.1	4.9	1.5	1.1	4.6	1.5	1.1	4.5	1.6	1.3	4.2
Kent	1.4	1.1	2.7	1.5	1.2	2.7	1.5	1.3	2.3	1.6	1.2	2.9
Less than 20	2.3	2.0	3.0	2.7	2.3	3.2	2.5	2.5	2.6	2.0	2.0	2.1
20-24	1.3	0.8	2.9	1.3	0.9	2.5	1.2	0.9	2.2	1.6	1.1	3.1
25-29	1.0	0.9	1.3	1.1	1.0	1.4	1.2	1.2	1.1	1.5	1.3	2.0
30+	1.6	1.3	3.5	1.6	1.2	3.8	1.6	1.1	3.8	1.7	1.1	4.4
Sussex	1.2	0.8	2.4	1.4	1.0	2.5	1.4	1.0	2.4	1.5	1.1	2.5
Less than 20	2.0	0.4	2.8	2.3	0.8	3.0	2.3	0.8	3.1	2.7	1.1	3.8
20-24	1.4	0.9	2.3	1.5	1.0	2.3	1.4	1.1	2.0	1.5	1.2	2.0
25-29	0.9	0.8	2.6	1.1	1.0	2.6	1.1	1.1	2.5	1.0	1.0	2.8
30+	0.9	0.8	1.5	1.0	1.0	1.8	1.0	1.0	1.5	1.2	1.2	0.9

Note: Very Low Birth Weight (<1500 grams) is a subdivision of Low Birth Weight (<2500 grams).
Source: Delaware Health Statistics Center

Table 13:

Prenatal Care

Percent of Mothers Receiving Prenatal Care in The First Trimester of Pregnancy Delaware, Counties, and City of Wilmington, 1987–1997

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
U.S.	74.4	74.2	73.9	74.2	74.6	76.1	77.1	78.4	79.4	79.7	80.4
Delaware	77.0	79.5	77.0	78.9	77.4	80.1	81.6	82.3	84.7	82.6	82.0
White	82.5	85.0	83.4	84.9	83.8	86.4	86.0	86.8	88.1	86.0	85.7
Black	58.9	60.7	56.7	59.3	59.1	60.9	67.3	67.6	73.7	71.7	71.0
Other	79.5	86.4	77.6	82.6	80.5	77.9	79.2	84.4	84.1	81.7	82.0
New Castle	81.0	83.1	80.2	83.0	80.1	84.3	88.9	90.2	90.6	88.6	87.2
Wilmington	71.3	67.1	65.0	68.1	62.1	68.2	78.8	80.7	81.8	80.3	77.8
Kent	74.7	75.3	70.7	71.5	75.4	76.0	66.9	64.1	73.1	68.9	67.8
Sussex	63.2	69.2	70.8	70.6	68.7	67.6	69.3	71.9	74.1	74.4	76.4

Source: Delaware Health Statistics Center, National Center for Health Statistics

Table 14:

Prenatal Care by Race

Percent of Mothers Receiving Prenatal Care in The First Trimester of Pregnancy by Race Delaware, Counties, and City of Wilmington, 1997

Area	All Races	White	Black	Other
Delaware	82.0	85.7	71.0	82.0
New Castle	87.2	91.0	76.0	86.8
Wilmington	77.8	87.9	72.6	66.7
Balance of NCC	89.3	91.3	78.9	88.2
Kent	67.8	71.1	57.7	65.1
Sussex	76.4	80.1	65.0	70.6

Source: Delaware Health Statistics Center

Table 15:

Births by Birth Weight, Race of Mother and Adequacy of Prenatal Care

Number and Percent of Live Births by Race of Mother, Birth Weight in Grams and Adequacy of Prenatal Care (Percentages Calculated by Birth Weight Group) Delaware, 1993–1997

	Total		Adequate		Intermediate		Inadequate		Unknown	
Birth Weight (g)	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Delaware	51,599	100.0	38,209	74.0	10,350	20.1	2,414	4.7	626	1.2
<2500	4,233	100.0	2,745	64.8	1,018	24.0	361	8.5	109	2.6
<1500	870	100.0	572	65.7	186	21.4	76	8.7	36	4.1
1500-2499	3,363	100.0	2,173	64.6	832	24.7	285	8.5	73	2.2
2500+	47,347	100.0	35,463	74.9	9,327	19.7	2,050	4.3	507	1.1
Unknown	19	100.0	1	5.3	5	26.3	3	15.8	10	52.6
White	38,328	100.0	29,945	78.1	6,761	17.6	1,193	3.1	429	1.1
<2500	2,494	100.0	1,789	71.7	526	21.1	119	4.8	60	2.4
<1500	457	100.0	326	71.3	88	19.3	25	5.5	18	3.9
1500-2499	2,037	100.0	1,463	71.8	438	21.5	94	4.6	42	2.1
2500+	35,815	100.0	28,155	78.6	6,230	17.4	1,071	3.0	359	1.0
Unknown	19	100.0	1	5.3	5	26.3	3	15.8	10	52.6
Black	12,017	100.0	7,345	61.1	3,336	27.8	1,163	9.7	173	1.4
<2500	1,623	100.0	879	54.2	465	28.7	237	14.6	42	2.6
<1500	396	100.0	234	59.1	96	24.2	50	12.6	16	4.0
1500-2499	1,227	100.0	645	52.6	369	30.1	187	15.2	26	2.1
2500+	10,394	100.0	6,466	62.2	2,871	27.6	926	8.9	131	1.3
Unknown	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Other	1,254	100.0	919	73.3	253	20.2	58	4.6	24	1.9
<2500	116	100.0	77	66.4	27	23.3	5	4.3	7	6.0
<1500	17	100.0	12	70.6	2	11.8	1	5.9	2	11.8
1500-2499	99	100.0	65	65.7	25	25.3	4	4.0	5	5.1
2500+	1138	100.0	842	74.0	226	19.9	53	4.7	17	1.5
Unknown	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

Source: Delaware Health Statistics Center

Table 16:

Births by Birth Weight, Age of Mother and Adequacy of Prenatal Care

Number and Percent of Live Births by Age of Mother, Birth Weight in Grams and Adequacy of Prenatal Care (Percentages Calculated by Birth Weight Group) Delaware, 1993–1997

Age / Birth Weight (g)	Total		Adequate		Intermediate		Inadequate		Unknown	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Less than 20 yrs.	6,802	100.0	3,877	57.0	2,171	31.9	650	9.6	104	1.5
<2500	724	100.0	356	49.2	233	32.2	109	15.1	26	3.6
<1500	148	100.0	85	57.4	36	24.3	19	12.8	8	5.4
1500-2499	576	100.0	271	47.0	197	34.2	90	15.6	18	3.1
2500+	6,076	100.0	3,521	57.9	1,937	31.9	540	8.9	78	1.3
Unknown	2	100.0	0	0.0	1	50.0	1	50.0	0	0.0
20-24 Years	11,602	100.0	7,892	68.0	2,760	23.8	789	6.8	161	1.4
<2500	987	100.0	619	62.7	241	24.4	102	10.3	25	2.5
<1500	208	100.0	130	62.5	44	21.2	29	13.9	5	2.4
1500-2499	779	100.0	489	62.8	197	25.3	73	9.4	20	2.6
2500+	10,612	100.0	7,273	68.5	2,518	23.7	685	6.5	136	1.3
Unknown	3	100.0	0	0.0	1	33.3	2	66.7	0	0.0
25-29 Years	14,810	100.0	11,635	78.6	2,532	17.1	474	3.2	169	1.1
<2500	1,069	100.0	725	67.8	250	23.4	68	6.4	26	2.4
<1500	224	100.0	149	66.5	51	22.8	13	5.8	11	4.9
1500-2499	845	100.0	576	68.2	199	23.6	55	6.5	15	1.8
2500+	13,735	100.0	10,910	79.4	2,281	16.6	406	3.0	138	1.0
Unknown	6	100.0	0	0.0	1	16.7	0	0.0	5	83.3
30-34 Years	12,815	100.0	10,318	80.5	2,028	15.8	334	2.6	135	1.1
<2500	962	100.0	693	72.0	200	20.8	47	4.9	22	2.3
<1500	186	100.0	137	73.7	35	18.8	7	3.8	7	3.8
1500-2499	776	100.0	556	71.6	165	21.3	40	5.2	15	1.9
2500+	11,846	100.0	9,624	81.2	1,827	15.4	287	2.4	108	0.9
Unknown	7	100.0	1	14.3	1	14.3	0	0.0	5	71.4
35+ Years	5,570	100.0	4,487	80.6	859	15.4	167	3.0	57	1.0
<2500	491	100.0	352	71.7	94	19.1	35	7.1	10	2.0
<1500	104	100.0	71	68.3	20	19.2	8	7.7	5	4.8
1500-2499	387	100.0	281	72.6	74	19.1	27	7.0	5	1.3
2500+	5,078	100.0	4,135	81.4	764	15.0	132	2.6	47	0.9
Unknown	1	100.0	0	0.0	1	100.0	0	0.0	0	0.0

Source: Delaware Health Statistics Center

Table 17:

Births by Birth Weight, Marital Status, and Adequacy of Prenatal Care

Number and Percent of Live Births by Marital Status, Birth Weight in Grams, and Adequacy of Prenatal Care (Percentages Calculated by Birth Weight Group), Delaware, 1993–1997

Marital Status / Birth Weight (g)	Adequate		Intermediate		Inadequate		Unknown	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Married	27,256	81.2	5,238	15.6	695	2.1	359	1.1
<2500 (low birth weight)	1,641	75.8	416	19.2	58	2.7	51	2.4
<1500 (very low birth weight)	316	75.6	69	16.5	12	2.9	21	5.0
1500-2499	1,325	75.8	347	19.9	46	2.6	30	1.7
2500+	25,614	81.7	4,817	15.4	635	2.0	299	1.0
Unknown	1	5.9	5	29.4	2	11.8	9	52.9
Single	10,953	60.7	5,112	28.3	1,719	9.5	267	1.5
<2500 (low birth weight)	1,104	53.4	602	29.1	303	14.7	58	2.8
<1500 (very low birth weight)	256	56.6	117	25.9	64	14.2	15	3.3
1500-2499	848	52.5	485	30.0	239	14.8	43	2.7
2500+	9,849	61.6	4,510	28.2	1,415	8.9	208	1.3
Unknown	0	0.0	0	0.0	1	50.0	1	50.0

Source: Delaware Health Statistics Center

Table 18:

Infant, Neonatal and Postneonatal Mortality Rates

Five-Year Average Infant Mortality Rates, Neonatal and Postneonatal Mortality Rates U.S. and Delaware, 1990–1997

Area/Race	1990-1994			1991-1995			1992-1996			1993-1997		
	Infant	Neo-natal	Post-neonatal	Infant	Neo-natal	Post-neonatal	Infant	Neo-natal	Post-neonatal	Infant	Neo-natal	Post-neonatal
U.S.	8.6	5.4	3.2	8.3	5.3	3.0	8.0	5.1	2.9	7.7*	4.9*	2.7*
White	7.0	4.4	2.6	6.8	4.3	2.5	6.5	4.2	2.4	6.3*	4.1*	2.3*
Black	17.0	10.9	6.0	16.4	10.6	5.8	15.8	10.2	5.6	15.2*	9.8*	5.3*
Delaware	9.3	6.4	2.9	8.9	6.0	2.9	7.9	5.4	2.5	7.8	5.3	2.5
White	6.6	4.7	1.9	6.4	4.5	2.0	5.6	3.8	1.8	5.6	3.7	1.9
Black	18.2	12.1	6.1	17.0	11.1	5.9	15.7	10.7	5.1	14.7	10.4	4.3

* Based on National Center for Health Statistics estimate
Neonatal – the period from birth to 27 days; **Post-neonatal** – the period from 28 days to one year; **Infant** – the period from birth to one year;
Infant Mortality Rate – calculated in deaths per 1,000 deliveries
Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 19:

Infant Mortality Rates by Race

Five-Year Average Infant Mortality Rates by Race
U.S., Delaware, Counties and City of Wilmington, 1982–1997

Area/Race	1982-1986	1983-1987	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	10.9	10.6	10.4	10.2	9.9	9.6	9.3	9.0	8.6	8.3	8.0	7.7*
White	9.5	9.2	9.0	8.7	8.3	8.0	7.7	7.3	7.0	6.8	6.5	6.3*
Black	18.7	18.3	18.0	18.1	18.0	17.9	17.7	17.5	17.0	16.4	15.8	15.2*
Delaware	12.2	11.8	12.1	12.3	11.3	11.5	10.9	10.4	9.3	8.9	7.9	7.8
White	9.7	9.3	9.6	9.9	8.9	8.9	8.2	7.5	6.6	6.4	5.6	5.6
Black	20.7	19.9	20.6	20.7	19.6	20.0	19.8	19.9	18.2	17.0	15.7	14.7
New Castle	13.1	12.6	12.4	12.5	11.2	11.3	10.8	10.7	9.5	9.0	7.8	7.3
White	10.1	9.6	9.5	9.6	8.4	8.6	7.9	7.5	6.5	6.3	5.0	4.9
Black	23.9	23.4	23.2	23.1	21.1	20.8	20.8	21.7	19.8	18.3	17.5	15.3
Wilmington	N/A	N/A	N/A	N/A	20.9	20.4	19.6	19.5	18.0	16.6	15.2	13.6
White	N/A	N/A	N/A	N/A	16.2	14.1	12.3	11.2	9.7	10.1	6.2	6.4
Black	N/A	N/A	N/A	N/A	23.8	24.2	23.8	24.3	22.8	20.4	20.5	17.8
Balance of NC Co.	N/A	N/A	N/A	N/A	8.6	9.0	8.6	8.5	7.5	7.2	6.1	5.9
White	N/A	N/A	N/A	N/A	7.6	8.1	7.4	7.1	6.2	5.9	4.8	4.8
Black	N/A	N/A	N/A	N/A	17.3	16.4	17.1	18.5	16.3	16.0	14.4	12.9
Kent	9.8	9.7	11.3	11.1	11.2	11.3	11.3	9.7	9.6	8.6	8.6	8.2
White	8.7	9.3	10.5	9.9	9.4	9.0	8.8	7.3	7.3	6.5	6.8	5.9
Black	13.5	11.3	14.4	15.6	17.7	19.0	19.9	17.9	17.6	15.5	15.1	16.5
Sussex	11.6	11.0	11.8	12.8	12.2	12.2	10.7	9.7	8.3	8.7	7.9	9.0
White	9.0	8.2	9.1	10.8	10.5	10.1	8.8	7.8	6.2	6.8	6.8	8.0
Black	17.9	17.8	18.5	18.0	16.8	18.0	16.1	15.3	13.7	13.9	10.4	11.1

Mortality Rates are deaths per 1,000 live births
* Based on National Center for Health Statistics estimate
Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 20:

Infant Mortality Rates by Risk Factor

Infant Mortality Rates per 1,000 Live Births by Risk Factor (Live Birth Cohort) Delaware, 1992–1996

Risk Factor	All Races	White	Black
Birth Weight			
<1500 grams	272.9	239.3	306.1
<2500 grams	68.7	58.4	85.3
2500+ grams	2.3	2.0	3.3
Age of Mother			
<20	12.1	10.3	14.6
20-24	10.0	6.5	17.3
25-29	6.6	3.6	11.6
30+	5.2	4.1	12.0
Adequacy of Prenatal Care			
Adequate	6.4	4.7	13.1
Intermediate	7.6	5.9	10.8
Inadequate	22.8	18.7	27.8
Marital Status of Mother			
Married	4.9	4.6	7.1
Single	12.8	8.9	16.9
Education of Mother			
<12 years	10.1	8.3	13.6
High School diploma	9.2	6.3	17.2
1+ years of college	5.0	4.0	9.9

Source: Delaware Health Statistics Center

Table 21:

Infant Deaths by Causes of Death and Race of Mother

Number and Percent of Infant Deaths by Selected Leading Causes of Death by Race of Mother (all birth weights) Delaware, 1992–1996

Cause of Death	All Races		White		Black		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All Causes	396	100.0	215	100.0	172	100.0	9	100.0
Birth Defects	73	18.4	56	26.0	15	8.7	2	22.2
Certain Conditions Originating in the Perinatal Period	203	51.3	92	42.8	105	61.0	6	66.7
Disorders relating to short gestation and unspecified low birth weight (Included in figures above)	89	22.5	36	16.7	49	28.5	4	44.4
Symptom, Signs, and Ill-defined Conditions (Includes Sudden Infant Death Syndrome)	50	12.6	27	12.6	22	12.8	1	11.1
Infectious and Parasitic Diseases	14	3.5	6	2.8	8	4.7	0	0.0
Unintentional Injuries	9	2.3	5	2.3	4	2.3	0	0.0
Homicide	3	0.8	2	0.9	1	0.6	0	0.0
Diseases of the Respiratory System	8	2.0	5	2.3	3	1.7	0	0.0
All Other Causes	36	9.1	22	10.2	14	8.1	0	0.0

Infant deaths are deaths that occur between live birth and one year of age
Percentages are based upon the total number of infant deaths in each race group. Percentages may not add up to 100% due to rounding.
Live Birth Cohort – All persons born during a given period of time.
Source: Delaware Health Statistics Center

Table 22:

Child Death Rates

Five-Year Average Death Rates, Children 1-14 Years of Age U.S. and Delaware, 1982–1997

	1982-1986	1983-1987	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	34.9	34.3	33.9	33.6	33.0	32.3	31.3	30.5	29.7	29.1	28.3	N/A
Delaware	37.0	37.8	35.3	35.3	34.3	32.1	30.3	29.9	26.6	24.5	23.3	23.5

Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 23:

Causes of Deaths of Children by Age

Five Leading Causes of Deaths of Children 1–19 Years Old, by Age
Delaware, 1993–1997

Age	Cause of Death	Deaths	
		Number	Percent
1-4 Years	Unintentional Injuries*	23	32.9
	Birth Defects	10	14.3
	Homicide	9	12.9
	Heart Diseases	4	5.7
	Cancer	2	2.9
	All Other Causes	22	31.4
	Total	70	100.0
5-14 Years	Unintentional Injuries*	34	37.0
	Cancer	17	18.5
	Homicide	6	6.5
	Birth Defects	5	5.4
	Suicide	5	5.4
	All Other Causes	25	27.2
	Total	92	100.0
15-19 Years	Unintentional Injuries*	86	55.8
	Suicide	18	11.7
	Homicide	18	11.7
	Cancer	8	5.2
	Heart Diseases	3	1.9
	All Other Causes	21	13.6
	Total	154	100.0

* Mator vehicle accidents are included as part of unintentional injuries
Source: Delaware Health Statistics Center

Table 24:

Teen Death Rates

Five-Year Average Teen Death Rates by Accident, Homicide, and Suicide, Teens 15–19 Years of Age U.S. and Delaware, 1982–1997

	1982-1986	1983-1987	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	63.7	63.8	65.2	66.4	68.1	68.7	68.9	69.0	69.1	68.0	66.1	N/A
Delaware	49.1	43.5	50.4	50.1	52.2	47.5	47.6	43.1	44.9	45.2	47.4	51.1

Sources: Delaware Health Statistics Center; National Center for Health Statistics

Table 25:

Traffic Arrests of Teens

Number of Arrests for Teens Involved in Crashes, Delaware, Five Year Averages

	1992-96	1993-97	1994-98
No insurance	41.0	44.0	51.0
Disobey traffic devise	83.6	98.4	116.4
Unsafe lane change	50.6	56.8	64.4
Following too closely	191.6	205.2	228.6
Unsafe left turn	108.0	112.6	128.6
Entering roadway unsafely	51.6	50.0	54.6
Stop sign violations	156.0	168.6	180.4
Unsafe speed	165.2	176.8	190.6
Careless driving	373.0	398.2	427.6
Inattentive driving	515.4	567.4	647.4
Driving under the influence	34.8	42.4	721.8
Other traffic arrests	334.8	359.6	388.8
Average Total Traffic Arrests	2,105.6	2,280.0	2,527.0

Source: Delaware State Police

Table 26:

Violent Juvenile Arrests

Juvenile Violent Crime Arrests, Delaware and Counties, 1988–1997

Area	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Delaware	191	214	374	594	537	525	514	588	629	549
New Castle	139	133	251	254	317	328	321	382	414	334
Kent	24	38	54	70	107	100	90	93	102	96
Sussex	29	43	69	70	113	97	103	113	113	119

Source: Statistical Analysis Center

Table 27:

Juvenile Part I Violent Crime Arrests

Arrest of Children under 18 Years of Age by Type of Crime, Delaware, 1988–1997

Crime Type	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Part 1 Violent	191	214	374	394	537	525	514	588	629	549
Murder, Nonneg. Manslaughter	2	4	5	5	3	2	2	4	8	0
Manslaughter by Negligence	3	1	0	1	2	3	1	1	0	2
Forcible Rape	39	33	47	50	57	70	47	52	49	62
Robbery	51	28	105	88	133	121	144	171	168	141
Aggravated Assault	96	148	215	250	342	329	320	360	404	344

Source: Statistical Analysis Center

Table 28:

Juvenile Part I Property Crime Arrests

Juvenile Arrests for Part I Property Crimes*, Delaware and County, 1990–1997

	1990	1991	1992	1993	1994	1995	1996	1997
Delaware	1,961	1,964	2,307	2,159	2,211	2,156	2,225	1,957
New Castle	1,231	1,233	1,443	1,372	1,363	1,305	1,248	1,060
Kent	440	452	528	374	470	415	527	482
Sussex	290	279	336	413	378	436	450	415

* Part 1 Property Crimes: Burglary- Breaking or Entering, Larceny- Theft (Except MV Theft), Arson
Source: Statisticol Anolysis Center

Table 29:

Juvenile Part II Crime Arrests

Juvenile Arrests for Part II Crimes*, Delaware and County, 1990–1997

	1990	1991	1992	1993	1994	1995	1996	1997
Delaware	3,955	4,018	3,795	4,005	3,911	4,492	4,869	4,500
New Castle	2,556	2,649	2,260	2,363	2,173	2,456	2,637	2,441
Kent	658	631	695	740	756	852	927	914
Sussex	741	738	840	702	982	1,184	1,305	1,145

* Part II Offenses: Drug Abuse Violations (Sales/Manufacturing and Possession), Other Assoults, Froud, Stolen Property (Buying, Receiving, Possessing, etc.), Sex Offenses (except Rape and Prostitution), Liquor Laws, Disorderly Conduct, All Other Offenses (Except Traffic), Curfew and Loitering Law Violation

Source: Statistical Analysis Center

Table 30:

Juvenile Drug Arrests

Arrest of Children under 18 Years of Age by Type of Crime, Delaware, 1988–1996

Crime Type	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Drug Offenses	163	296	277	374	295	316	398	567	590	576
Drug Sales, Manufacturing	25	55	72	101	65	63	63	84	67	53
Opium, Cocaine & Derivatives	21	46	66	90	60	53	57	72	52	40
Marijuana	4	6	6	9	5	10	6	11	12	12
Synthetic/ Manufactured narcotics	0	1	0	0	0	0	0	0	3	0
Other Dangerous Non-Narcotics	0	2	0	2	0	0	0	1	0	1
Drug Possession	140	241	205	273	230	253	335	483	523	523
Opium, Cocaine & Derivatives	53	121	132	205	145	104	118	122	99	128
Marijuana	83	116	73	63	74	148	212	350	408	362
Synthetic/ Manufactured Narcotics	0	0	0	0	0	0	0	2	0	0
Other Dangerous Non-Narcotics	4	4	0	5	11	1	5	9	16	13

Source: Statisticol Analysis Center

Table 31:

8th Graders Using Substances

Percent of Participants in Delaware Survey of Public School 8th graders Using Substances (Cigarettes, Alcohol, Marijuana) in the Last 30 Days by Gender, Delaware and Counties, 1998

Area/Gender	Cigarettes	Alcahal	Marijuana
Delaware	24	29	19
Male	21	25	19
Female	27	33	19
New Castle	24	31	20
Male	21	26	18
Female	28	35	21
Kent	27	30	21
Male	27	28	23
Female	27	30	19
Sussex	22	25	15
Male	19	28	17
Female	25	30	12

Source: The Center for Drug and Alcahol Studies, University of Delaware and the Office of Prevention, Delaware Department of Services for Children, Youth and Their Families

Table 32:

11th Graders Using Substances

Percent of Participants in Delaware Survey of Public School 11th graders Using Substances (Cigarettes, Alcohol, Marijuana) in the Last 30 Days by Gender, Delaware and Counties, 1998

Area/Gender	Cigarettes	Alcahal	Marijuana
Delaware	33	47	25
Male	33	49	28
Female	33	45	23
New Castle	30	42	24
Male	28	43	27
Female	31	41	22
Kent	34	49	28
Male	40	58	30
Female	29	41	27
Sussex	39	53	25
Male	39	55	31
Female	39	52	21

Source: The Center for Drug and Alcahol Studies, University of Delaware and the Office of Prevention, Delaware Department of Services for Children, Youth and Their Families

Table 33:

Student Violence and Possession

Reports of Student Violence and Possession (Delaware Code, Title 14, §4112* and SBE**) Delaware and Counties, 1996–1997 School Year

Type of Incident	New Castle County	Kent County	Sussex County	Delaware Totals***
Assault against pupil	420	91	81	598
Extortion against pupil	7	0	1	8
Total reports against pupils	**427**	**91**	**82**	**606**
Assault against employee	62	14	16	93
Extortion against employee	0	0	0	0
Offensive touching against employee	284	36	51	371
Terroristic threatening against employee	83	26	28	142
Total reports against employees	**429**	**76**	**95**	**606**
Possess dangerous instrument/weapon	125	27	37	191
Possess controlled substance	115	62	54	237
Total reports of possession	**240**	**89**	**91**	**428**
Total of §4112 reports filed	**1,096**	**256**	**268**	**1,640**
Total SBE filed	120	42	59	227
Total reports filed	**1,216**	**298**	**327**	**1,867**

* **Delaware Code, Title 14, §4112:** Signed in July 1993 requires that evidence of certain incidents of student conduct that occur in Delaware schools be reported to the Secretary of Education and to the Youth Division of the Delaware State Police

** **SBE (State Board of Education) Reports:** Expands the reporting requirements of Delaware Code, Title 14, §4112 to include evidence of other incidents involving school children such as arson and forgery.

*** Alternative Schools are not included in county breakdowns but are included in Delaware total.

Source: Delaware Department of Education

Table 34:

Student Violence and Possession Charges Filed

Incidents in which Police Charges Were Filed Delaware, 1996–1997 School Year

Incident	Reports	Charges Filed	Percent of Reports Leading to Charges Filed
Title 14, §4112 incidents against pupils	606	132	22%
Title 14, §4112 incidents against employees	606	217	36%
Possession of dangerous instrument/weapon	191	47	25%
Possession of unlawful controlled substance	237	109	46%
SBE incidents	227	64	28%
Total incidents	**1,867**	**569**	**30%**

Source: Delaware Department of Education

Table 35:

Student Violence and Possession by Age

Student Violence Data (Delaware Code, Title 14, §4112* and SBE**) by Number and Age of Perpetrators Delaware 1996–1997 School Year

	Ages 4–6	Ages 7–9	Ages 10–12	Ages 13–15	Ages 16–21	Total
Number of Students	47	177	469	849	430	1,972
Percent of students involved in violent incidents that are in this age group	2%	9%	24%	43%	22%	100.0%

* **Delaware Code, Title 14, §4112:** Signed in July 1993 requires that evidence of certain incidents of student conduct that occur in Delaware schools be reported to the Secretary of Education and to the Youth Division of the Delaware State Police.

** **SBE (State Board of Education) Reports:** Expands the reporting requirements of Delaware Code, Title 14, §4112 to include evidence of other incidents involving school children such as arson and forgery.

Source: Delaware Department of Education

Table 36:

Student Violence and Possession by Gender and Ethnicity

Student Violence Data (Delaware Code, Title 14, §4112* and SBE**) by Gender and Ethnicity of Perpetrators Delaware, 1996–1997 School Year

Ethnicity of Perpetrators	Female	% of Total Perpetrators	Male	% of Total Perpetrators	Total	% of Total Perpetrators
American Indian	0	0.0	3	0.2	3	0.2
Asian	1	0.1	7	0.4	8	0.4
African American	271	13.7	795	40.3	1,066	54.1
Hispanic	19	1.0	64	3.2	83	4.2
White	166	8.4	646	32.8	812	41.2
Total	**457**	**23.2**	**1,515**	**76.8**	**1,972**	**100.0**

* **Delaware Code, Title 14, §4112:** Signed in July 1993 requires that evidence of certain incidents of student conduct that occur in Delaware schools be reported to the Secretary of Education and to the Youth Division of the Delaware State Police

** **SBE (State Board of Education) Reports:** Expands the reporting requirements of Delaware Code, Title 14, §4112 to include evidence of other incidents involving school children such as arson and forgery.

Source: Delaware Department of Education

Table 37:

Violent Adult Arrests

Violent Arrest Rate Per 1,000 Population Adults 18 and Over, Delaware, 1985–1997

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Adult Violent Arrests	1,142	1,153	967	1,177	1,488	1,878	1,923	2,065	1,978	1,997	2,155	2,200	2,286
Rate	2.48	2.48	2.03	2.43	3.01	3.75	3.78	4.00	3.77	3.74	4.19	4.22	4.11

Source: Statistical Analysis Center

Table 38:

Violent Adult Arrests, Adults 18–39

Violent Arrest Rates Per 1,000 Population Adults 18–39 Only, Delaware, 1985–1997

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Rate	4.92	4.92	4.08	4.90	6.13	7.65	7.79	8.32	7.92	7.94	8.54	8.72	9.09

Source: Statistical Analysis Center

Table 39:

Dropouts

Delaware Dropouts 1997–1998, Summary Statistics Grades 9–12

	Annual Dropout Rate (%)	Percentage of All Dropouts (%)
Total	4.5	100.0
Gender		
Male	5.5	60
Female	3.9	40
Race/Ethnicity		
American Indian	2.9	0.1
African American	6.4	38.9
Hispanic	8.2	6.5
White	3.8	54.4

Source: Delaware Department of Education

Table 40:

Dropouts and Enrollment by Race

Delaware Dropouts and Student Enrollment by Race, Public School Students Grades 9–12 Delaware and Counties, 1997–1998 School Year

Area	Number of Enrolled Students, Grades 9–12				Number of Dropouts, Grades 9–12			
	Black	Hispanic	White/ Other	All	Black	Hispanic	White/ Other	All
Delaware	9,535	1,254	22,399	33,188	608	103	851	1,562
New Castle	6,050	905	12,557	19,512	389	85	490	964
Kent	1,817	177	5,051	7,045	102	8	155	265
Sussex	1,668	172	4,791	6,631	117	10	206	333

Source: Delaware Department of Education

Table 41:

Dropout Rate and Percentage by Race

Dropout Rate and Percentage of all Dropouts by Race, Public School Students Delaware and Counties, 1997–1998 School Year

County	Annual Dropout Rate				Percentage of All Dropouts			
	Black	Hispanic	White/ Other	All	Black	Hispanic	White/ Other	All
Delaware	6.4	8.2	3.8	4.7	38.9	6.5	54.4	100.0
New Castle	6.4	9.4	3.9	4.9	24.9	5.4	31.3	61.7
Kent	5.6	4.5	3.1	3.8	6.5	0.5	9.9	16.9
Sussex	7.0	5.8	4.3	5.0	7.4	0.6	13.1	21.3

Source: Delaware Department of Education

Table 42:

Dropouts and Enrollment by Race and Gender

Student Enrollment and Delaware Dropouts by Race and Gender, Grades 9–12 Public School Students in Delaware, 1997–1998 School Year

Gender	Number of Enrolled Students, Grades 9–12				Number of Dropouts, Grades 9–12			
	Black	Hispanic	White/ Other	All	Black	Hispanic	White/ Other	All
Delaware	9,535	1,254	22,399	33,188	608	103	851	1,562
Male	4,807	654	11,576	17,037	358	65	513	936
Female	728	600	10,823	16,151	250	38	338	626

Source: Delaware Department of Education

Table 43:

Dropout Rate and Percentage by Race and Gender

Dropout Rate and Percentage of all Dropouts by Race and Gender, Grades 9–12 Public School Students in Delaware, 1997–1998 School Year

Gender	Annual Dropout Rate				Percentage of All Dropouts			
	Black	Hispanic	White/ Other	All	Black	Hispanic	White/ Other	All
Delaware	6.4	8.2	3.8	4.7	38.9	6.5	54.4	100.0
Male	7.4	9.9	4.4	5.5	22.9	4.1	32.8	60.0
Female	5.3	6.3	3.1	3.9	16.0	2.4	21.6	40.0

Source: Delaware Department of Education

Table 44:

Dropouts by Race and Ethnicity

Dropouts by Race/Ethnicity, Grades 9–12, Delaware, 1986–1998

Race/Ethnicity	1986-1987	1987-9188	1988-1989	1989-1990	1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998
Black	9.5	10.0	10.2	10.0	7.9	6.2	5.8	6.8	5.8	5.3	6.1	6.4
Hispanic	14.1	13.6	14.2	11.9	8.8	7.9	5.1	6.7	7.5	8.3	7.3	8.2
White	6.2	6.1	6.2	5.4	4.9	3.0	3.6	3.8	4.0	4.0	3.7	3.8
All	7.2	7.2	7.3	6.6	5.7	4.0	4.2	4.6	4.6	4.5	4.5	4.7

Source: Delaware Source: Delaware Department of Education

Table 45:

Teens Not in School and Not in the Labor Force

Number and Percentage of Teens (16–19 Yrs.) Not in School and Not in the Labor Force Delaware, Counties and City of Wilmington, 1990 Census

Area	Total	%*	White	%*	Black	%*	Other	%*	Hispanic Origin	%*
Delaware										
High School Graduate	472	1.3	310	1.1	152	2.0	10	0.9	5	0.5
Not High School Graduate	1,433	3.8	811	2.8	564	7.6	58	5.0	57	5.5
New Castle										
High School Graduate	313	1.2	212	1.0	91	2.0	10	1.2	5	0.7
Not High School Graduate	864	3.4	467	2.4	357	7.8	40	4.9	36	5.0
Wilmington										
High School Graduate	63	1.8	15	2.0	48	2.0	0	0.0	0	0.0
Not High School Graduate	349	10.1	60	7.9	270	11.1	19	7.2	25	7.1
Kent										
High School Graduate	73	1.1	58	1.2	15	0.9	0	0.0	0	0.0
Not High School Graduate	268	4.0	172	3.6	89	5.1	7	2.7	2	0.8
Sussex										
High School Graduate	86	1.6	40	1.0	46	4.0	0	0.0	0	0.0
Not high school graduate	301	5.6	172	4.2	118	10.2	11	11.6	19	23.5

* Percentage of all teens 16–19 years old
Source: U.S. Bureau of the Census

Table 46:

Teens Not in School and Not Employed

Three Year Average Percentage of Persons (16-19 Yrs.) Not in School and Not Employed U.S. and Delaware, 1986–1998

	1986-1988	1987-1989	1988-1990	1989-1991	1990-1992	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998
U.S.	9.8	9.6	9.3	9.4	9.6	9.8	9.6	9.2	9.1	9.0	8.6
Delaware	7.0	7.5	10.3	9.0	7.4	10.8	9.6	9.8	7.3	6.9	7.1

Source: Center for Applied Demography and Survey Research, University of Delaware

Table 47:

Income of Families with Children by Family Type

Three-Year Average Median Income in U.S. Dollars of Households with Children under 18 by Family Type U.S. and Delaware, 1986–1998

	1986-1988	1987-1989	1988-1990	1989-1991	1990-1992	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998
U.S.											
1-Parent	10,190	10,580	11,417	12,067	12,610	12,617	12,730	13,187	14,187	15,233	16,177
2-Parent	33,933	35,767	37,700	39,233	40,747	42,213	43,680	45,300	47,100	49,133	51,467
Delaware											
1-Parent	11,650	13,617	14,443	14,567	14,667	15,000	15,667	16,133	17,167	18,467	19,100
2-Parent	35,767	37,100	38,633	41,200	44,237	47,570	49,033	50,867	51,167	53,403	56,900

Source: Center for Applied Demography and Survey Research, University of Delaware

Table 48:

Subsidized Child Care

Number of Children in State Subsidized Child Care Projected Monthly Averages, Delaware, Fiscal Years 1995–1998

	1995	1996	1997	1998	1999
Delaware Totals	5,743	6,919	8,482	9,592	10,200
Welfare Reform*	3,316	3,366	3,742	4,262	3,743
Income Eligible**	2,427	3,553	4,740	5,330	6,457

* The welfare reform numbers refer to the number of children in families who received AFDC that year or received AFDC child care for one year after leaving the AFDC program.
** The income eligible numbers reflect the working poor families below 155% of poverty.
90% of children with authorization to receive subsidized child care attend in a given month.
Source: Delaware Department of Services for Children, Youth and Their Families

Table 49:

Free and Reduced Breakfasts

Average Number of Free and Reduced Breakfasts Served Daily and Percent of Total Served Delaware and Counties, 1992/93–1997/98 School Years

	1992-1993		1993-1994		1994-1995		1995-1996		1996-1997		1997-1998	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Delaware	11,537	84.6	12,375	83.4	12,612	82.8	12,484	82.2	12,215	82.2	14,209	81.4
New Castle	5,096	89.0	5,748	86.9	6,272	85.3	5,806	84.6	5,579	83.8	6,353	81.8
Kent	3,281	79.8	3,112	78.2	2,604	77.7	3,133	77.3	3,073	79.3	4,157	79.7
Sussex	3,160	80.8	3,515	82.1	3,736	83.2	3,545	82.3	3,563	82.3	3,699	82.2

Source: Delaware Department of Education

Table 50:

Free and Reduced Lunches

Average Number of Free and Reduced Lunches Served Daily and Percent to Total Enrollment Delaware and Counties, 1994/95–1997/98 School Years

		1994-1995		1995-1996		1996-1997		1997-1998	
		Number	%	Number	%	Number	%	Number	%
Delaware	Enrollment	107,013		108,461		110,245		112,026	
	Free	30,981		31,247		32,208		33,834	
	Reduced	5,389		5,892		6,088		6,955	
	Percent Free and Reduced		33.9		34.2		34.7		36.4
New Castle	Enrollment	62,414		63,440		64,609		66,154	
	Free	17,435		17,912		17,720		19,416	
	Reduced	2,782		3,120		3,223		3,657	
	Percent Free and Reduced		32.4		33.2		32.4		34.9
Kent	Enrollment	24,257		24,472		27,749		24,835	
	Free	6,903		6,533		7,056		7,024	
	Reduced	1,607		1,612		1,640		1,853	
	Percent Free and Reduced		35.1		33.3		35.1		35.7
Sussex	Enrollment	20,342		20,549		20,887		21,037	
	Free	6,643		6,802		7,432		7,394	
	Reduced	1,000		1,160		1,225		1,445	
	Percent Free and Reduced		37.8		38.7		41.4		42.0

Source: Delaware Department of Education

Table 51:

Children Without Health Insurance

Percentage of Children Not Covered by Health Insurance
U.S. and Delaware, Three-Year Moving Average, 1986–1997

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
U.S.	15.7	15.3	14.4	13.6	13.1	13.0	12.7	12.9	13.4	13.9	14.3	14.5
Delaware	15.1	14.9	11.6	11.8	11.4	13.4	10.7	10.8	10.2	12.1	12.4	13.7

Source: Center for Applied Demography and Survey Research, University of Delaware

Table 52:

Health Insurance

Three-Year Average Percentage Persons (0-64) without Health Insurance
U.S. and Delaware, 1983–1998

	83-85	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	96-98
U.S.	18.0	17.4	17.6	17.2	16.3	15.6	15.3	15.6	16.1	16.6	17.0	17.2	17.3	17.7
Delaware	16.0	16.9	16.9	16.7	14.1	14.0	14.2	15.7	14.2	14.0	14.2	15.8	15.8	15.7

Source: Center for Applied Demography and Survey Research, University of Delaware

Table 53:

Poverty Thresholds

Poverty Thresholds by Size of Family and Number of Related Children Under 18 Years
Annual Income in Dollars, U.S., 1997

	Related Children under 18 years old								
Size of Family Unit	None	One	Two	Three	Four	Five	Six	Seven	Eight +
One person under 65 years old	$8,480								
One Person 65 years old or older	7,818								
Two Persons, householder under 65	10,915	11,235							
Two Persons, householder 65 or older	9,853	11,193							
Three Persons	12,750	13,120	13,133						
Four Persons	16,813	17,088	16,530	16,588					
Five Persons	20,275	20,570	19,940	19,453	19,155				
Six Persons	23,320	23,413	22,930	22,468	21,780	21,373			
Seven Persons	26,833	27,000	26,423	26,020	25,270	24,395	23,435		
Eight Persons	30,010	30,275	29,730	29,253	28,575	27,715	26,820	26,593	
Nine Persons or more	36,100	36,275	35,793	35,388	34,723	33,808	32,980	32,775	31,513

Source: U.S. Census Bureau

Table 54:

Home Ownership

Percent of Home Ownership, U.S. and Delaware, 1989–1998

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
U.S.	63.9	63.9	64.1	64.1	64.5	64.0	64.7	65.4	65.7	66.3
Delaware	68.7	67.7	70.2	73.8	74.4	70.5	71.7	71.5	69.2	71.0

Source: Delaware State Housing Authority

Table 55:

Poverty Rates for One-Parent Families

Poverty Rates for One-Parent Female (FHH) and Male (MHH) Householder Families With Related Children Under 18 Years of Age Delaware and Counties, 1990 Census

Area	One-Parent FHH Families	FHH Families below poverty		One-Parent MHH Families	MHH Families below Poverty		Risk of Poverty Ratio (FHH vs. MHH)*
		Number	Percent		Number	Percent	
Delaware	17,625	5,609	31.8	4,083	555	13.6	2.3
New Castle	11,625	3,202	27.5	2,627	264	10.0	2.8
Kent	3,193	1,257	39.4	614	127	20.7	1.9
Sussex	2,807	1,150	41.0	842	164	19.5	2.1

* Female-headed one-parent families are 2.3 times more likely to be in poverty than male-headed one-parent families .
Source: Delaware Health Statistics Center; U.S. Bureau of the Census

Table 56:

Poverty Rates for Female Householder Families

Poverty Rates for One-Parent Female Householder (FHH) Families With Related Children Under 18 Years of Age Delaware and Counties, 1980 and 1990 Census

Area	1980			1990			Percent Change 1979–1989
	One-Parent FHH Families	FHH Families below poverty		One-Parent FHH Families	FHH Families below Poverty		
		Number	Percent		Number	Percent	
Delaware	15,210	6,122	40.2	17,625	5,609	31.8	-20.9
New Castle	10,318	4,006	38.8	11,625	3,202	27.5	-29.1
Kent	2,737	1,180	43.1	3,193	1,257	39.4	-8.6
Sussex	2,155	936	43.4	2,807	1,150	41.0	-5.5

Source: Delaware Health Statistics Center; U.S. Bureau of the Census

Table 57:

Percentage Female Headed Families in Poverty

Three-Year Average Percentage Families in Poverty with Single Female Head and Children Under 18 U.S. and Delaware, 1986–1998

	1986-1988	1987-1989	1988-1990	1989-1991	1990-1992	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998
U.S.	50.9	48.5	45.2	42.4	42.9	43.7	44.0	43.1	41.7	40.2	39.3
Delaware	42.2	37.7	32.4	26.0	25.5	26.6	31.2	33.0	31.2	28.2	28.0

Source: Center for Applied Demography and Survey Research, University of Delaware

Table 58:

Children in Poverty by Family Type

Related Children Under 18 in Poverty, Number and Percent by Family Type U.S. and Delaware, 1990 Census

	Children under 18 in Married Couple Families		Children under 18 in Female Headed Families		Children under 18 in Male Headed Families	
	Number in Poverty	Percentage in Poverty	Number in Poverty	Percentage in Poverty	Number in Poverty	Percentage in Poverty
U.S.	4,419,632	9.3	6,179,808	49.9	562,396	23.5
Delaware	5,282	4.3	12,471	39.9	944	14.0

Source: Population Reference Bureau; U.S. Bureau of the Census

Table 59:

Child Support Paid

Percent of Child Support That Is Paid U.S. and Delaware, Fiscal Years 1989–1998

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
U.S.	47.6	53.0	48.0	55.4	52.7	54.0	53.0	52.0	54.0	N/A
Delaware	61.0	58.7	58.4	59.3	56.1	59.9	62.0	61.4	60.2	61.0

Source: Office of Child Support Enforcement · 158 Report and Child Support Enforcement Annual Report to Congress

Table 60:

Percentage of Births to Single Mothers

Five Year Average Percentage of Live Births to Single Mothers U.S., Delaware, Counties, 1984–1997

Area/Race	1984-1988	1985-1989	1986-1990	1987-1991	1988-1992	1989-1993	1990-1994	1991-1995	1992-1996	1993-1997
U.S.	23.4	24.6	25.8	27.0	28.1	29.1	30.2	31.1	31.6	32.1
White	15.6	16.8	18.0	19.2	20.4	21.5	22.7	23.7	24.5	25.2
Black	61.3	62.6	63.9	65.2	66.4	67.4	68.3	69.0	69.7	70.0
Delaware	26.4	27.3	27.9	28.9	29.9	31.3	32.3	33.5	34.3	35.0
White	14.2	14.9	15.4	16.3	17.3	18.6	20.0	21.5	22.7	23.7
Black	66.9	68.2	68.7	69.7	70.6	72.1	72.6	73.0	73.2	72.9
New Castle	25.5	26.3	26.7	27.6	28.7	29.8	30.7	31.8	32.3	32.7
White	13.7	14.2	14.5	15.1	16.1	17.2	18.3	19.8	20.7	21.3
Black	68.7	69.5	69.8	70.6	71.5	72.5	72.8	72.9	73.0	72.3
Kent	24.4	25.9	27.1	28.4	29.6	31.3	32.4	33.6	34.6	35.3
White	14.6	15.6	16.5	17.7	19.5	21.0	22.4	23.5	24.7	25.3
Black	56.9	59.2	60.6	62.0	62.4	64.8	65.9	67.0	68.4	69.0
Sussex	32.2	33.0	33.5	34.9	35.5	37.2	39.1	40.4	41.6	43.2
White	16.3	17.3	18.2	19.7	20.4	22.2	24.3	26.3	28.7	31.2
Black	71.1	72.9	73.2	74.9	75.5	77.8	78.2	78.5	78.0	78.6

Source: Delaware Health Statistics Center; National Center for Health Statistics

Table 61:

Unemployment

Unemployment Rates by Race and Gender U.S. and Delaware, 1985–1998

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
U.S., Total	7.2	7.0	6.2	5.5	5.3	5.6	6.8	7.5	6.9	6.1	5.6	5.4	4.9	4.5
Male	7.0	6.9	6.2	5.5	5.2	5.6	7.0	7.8	7.1	6.2	5.6	5.4	4.9	4.4
Female	7.4	7.1	6.2	5.5	5.2	5.6	7.0	7.8	7.1	6.2	5.6	5.4	4.9	4.6
White	6.2	6.0	5.3	4.7	4.5	4.7	6.0	6.5	6.0	5.3	4.9	4.7	4.2	3.9
Black	15.1	14.5	13.0	11.7	11.4	11.3	12.4	14.1	12.9	11.5	10.4	10.5	10.0	8.9
Delaware, Total	5.3	4.3	3.2	3.2	3.5	5.2	6.3	5.3	5.3	4.9	4.3	5.2	4.0	3.8
Male	5.0	4.4	3.0	3.4	3.2	5.6	7.2	5.9	5.5	4.5	4.6	5.8	4.4	4.0
Female	5.6	4.3	3.4	2.9	3.8	4.6	5.0	4.6	5.2	5.3	4.1	4.5	3.6	3.3
White	4.1	3.6	2.3	2.5	2.9	4.2	5.5	4.1	4.6	3.9	4.1	3.9	3.3	2.8
Black	12.2	8.6	6.6	7.5	6.6	9.3	9.2	10.6	9.5	9.5	4.9	10.1	6.7	6.7

*Preliminary data, subject to revision
Source: Delaware Department of Labor and U.S. Dept. of Labor, Bureau of Labor Statistics

Table 62:

Available Child Care

Number of Licensed Child Care Slots, Delaware, 1990–1997

	1990	1991	1992	1993	1994	1995	1996	1997	1998
Child Care Centers*	13,530	14,481	15,642	16,727	17,117	18,269	19,328	20,371	23,404
Family Child Care Homes**	8,889	10,400	11,070	11,891	11,459	16,412	14,935	15,197	14,297
Large Family Child Care Homes***	286	308	336	424	488	514	519	535	601
Totals	22,750	25,189	27,048	29,042	29,064	35,195	34,782	36,103	38,302

* Child Care Center– 13 or more children
** Family Child Care Homes– 1 person caring for more than 6 children
*** Large Family Child care Homes– 2 people caring for a group of 7-12 children
Source: Delaware Department of Services for Children, Youth and Their Families

Table 63:

School Age Programs

Number of School Age Programs, Delaware and Counties, 1998

Type of care	Delaware		New Castle County		Kent/Sussex County	
	Total	School Age	Total	School Age	Total	School Age
Child Care Centers	248	182	160	114	88	68
Family Child Care	1665	1429	1007	813	658	616
School Age Only	110	NA	74	NA	36	NA

Source: The Family and Workplace Connection

Table 64:

Site-Based School Age Programs

Number and Percent of School Age Child Care Located At Schools, Delaware and Counties, 1998

	Delaware			New Castle County			Kent/Sussex County		
	Total	School Age	%	Total	School Age	%	Total	School Age	%
Elementary Schools	103	65	63%	58	44	76%	45	21	47%
Middle Schools	29	2	7%	16	2	13%	13	0	0%

Source: The Family and Workplace Connection

Table 65:

Child Care Costs

Weekly Cost in Dollars to Families for Child Care by Child's Age Delaware, Wilmington, and Counties Counties, 1998

Age	Delaware			Wilmington			New Castle County			Kent/Sussex Counties		
	Min.	Average	High	Min.	Average	High	Min.	Average	High	Min.	Average	High
0–12 months	47	90	160	60	97	190	45	105	190	50	76	130
12–24 months	33	86	160	55	92	190	50	100	190	17	73	130
24–36 months	—	84	140	50	89	180	—	97	180	40	71	100
3 years old	39	82	146	50	87	180	38	95	180	40	70	112
4 years old	—	82	146	50	86	180	—	95	180	30	70	112
Kindergarten	—	80	—	35	77	180	—	95	—	20	65	112
School Age	15	47	107	25	52	100	20	52	115	10	42	100

Source: The Family and Workplace Connection

Table 66:

Child Abuse and Neglect

Reported and Confirmed Reports of Child Abuse/Neglect, Delaware 1990–1999

Fiscal Year	1993	1994	1995	1996	1997	1998	1999
Accepted reports	4,541	4,886	5,584	5,117	6,382	6,384	6,430
Substantiated reports	1,771	1,856	1,787	1,740	2,031	2,355	1,463

Source: Delaware Department of Services for Children, Youth and Their Families

Table 67:

Foster Care

Children in Foster Care, Delaware, Fiscal Years 1990-1999

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Average number of children per month	678	743	725	729	793	892	925	828	899	936

Sources: Delaware Department of Services for Children, Youth and Their Families
Child Abuse and Neglect: A look at the States (The CWLA Stat Book), Child Welfare League of Americo, Inc., Washington, D.C., 1995 and 1997.

Table 68:

Child Immunizations

Percent of Children Fully Immunized by Age 2+
U.S. and Delaware, 1994–1997

	Apr. 1994 – Mar. 1995	Jan. 1995–Dec. 1995	Jan. 1996–Dec. 1996	Jan. 1997–Dec. 1997
Delaware	81	75	81	81
U.S.	75	76	78	78

Source: Centers For Disease Control and Prevention

Table 69:

Lead Poisoning

Percent of Children under Age 6 with Blood Lead Levels at or Exceeding 15 mcg/dL
Delaware and U.S., Fiscal Years 1994–1999

	1994	1995	1996	1997	1998	1999
# Tested	7,998	8,959	9,848	9,243	9,117	9,958
# Identified	247	208	166	121	140	64
Delaware (%)	3.1	2.3	1.7	1.3	1.5	0.6
U.S. (%)	N/A	1.3	N/A	N/A	N/A	N/A

U.S. data only available for 1995
Source: Delaware Department of Health and Social Services, Division of Public health, Childhood Lead Poisoning Prevention Program

Table 70:

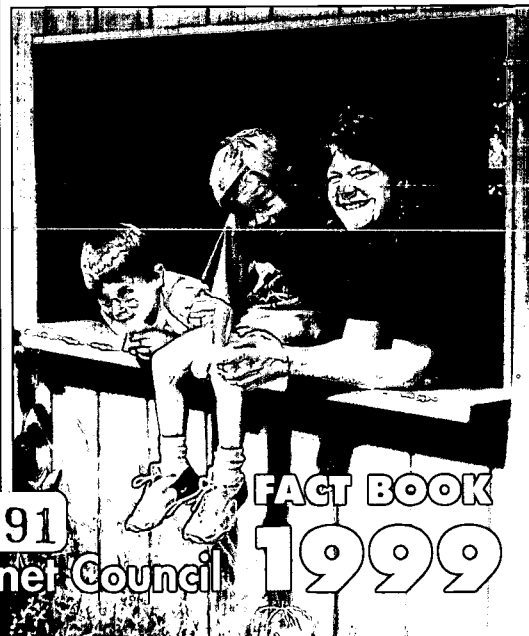
Sexually Transmitted Diseases

Number and Percent of Teens Ages 15–19 with Gonorrhea and Primary or Secondary Syphilis
Delaware, 1990–1998

	1990	1991	1992	1993	1994	1995	1996	1997	1998
Ganarrhea Cases	1,000	850	549	460	769	771	523	452	528
Primary ar Secandary Syphilis Cases	16	20	7	6	2	1	2	0	2
Tatal	1,016	870	556	466	771	772	525	452	530
Est. Papulatian 15-19 yrs.	46,454	46,100	45,768	45,453	45,159	44,886	45,943	47,029	45,308
Delaware (%)	2.2	1.9	1.22	1.0	1.7	1.7	1.1	1.0	1.0

Note: no reliable U.S. data are available
Source: Delaware Department of Health and Social Services, Division of Public Health

Families Count in Delaware



91

Family Services Cabinet Council

FACT BOOK 1999

STATE OF DELAWARE
OFFICE OF THE GOVERNOR

THOMAS R. CARPER
GOVERNOR

Dear Friends:

As the millennium draws to a close, I am pleased to report that Delaware is more focused than ever on families. This second publication of Families Count in Delaware caps an effort begun when I took office in 1993 to increase the quality and comprehensiveness of services to families through the Family Services Cabinet Council.

The Family Services Cabinet Council is a partnership between seven state departments whose mission it is to work every day with Delaware's families and children. It is this state partnership, which has stimulated further collaborations between non-profit human service agencies, public schools, higher education institutions, and many others, that brings us this report.

To serve Delaware's families best we must have information on their special needs and every day challenges. The Families Count book tells us—all of us—what we are doing right and what we can be doing better. As Governor, I look to this report and our many partners to carry us into the 21st Century with stronger, smarter, healthier families.

I hope you find this report helpful and informative in your continued efforts to spread the message "Families and Kids Count in Delaware!"

Sincerely,

Thomas R. Carper
Governor

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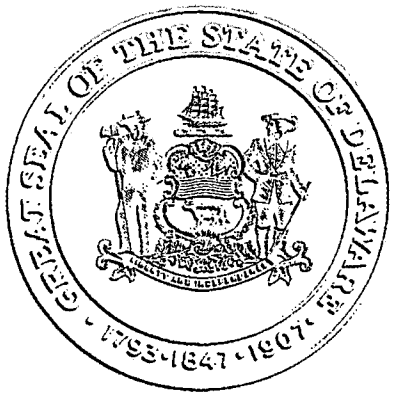

Family Services Cabinet Council

Families Count in Delaware

1999

FAMILIES COUNT in Delaware
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The photographs in this book do not necessarily represent the situations described.

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- Delaware State Housing Authority
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- Statistical Analysis Center

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Table of Contents

Families Count in Delaware

Family Services Cabinet Council Mission Statement:

To strengthen and support Delaware families and help children achieve their full potential within safe and caring communities.

Welcome to the second edition of *FAMILIES COUNT in Delaware*, a collaborative project of the Family Services Cabinet Council and KIDS COUNT in Delaware which is housed in the Center for Community Development and Family Policy at the University of Delaware. Since 1998 the Family Services Cabinet Council has been monitoring the conditions of families, children and individuals in the community by focusing on outcomes. Outcome measures are defined as measures of the results that occur, at least in part, because of services provided, for example, "percent of low birth weight babies." The focus on outcomes carries important implications:

- It allows us to communicate goals that the state and the public value for the well being of our families, children, and individuals.
- In communicating outcomes, we introduce accountability for improved conditions.
- An outcome focus will also allow for improved decision-making in service delivery, internal management, and allocation of resources.

Integral to the success of this program is public involvement in identifying needs and working toward improved conditions. Assembled in this second report are the indicators which quantify the outcomes. These indicators were developed by Governor Carper's Family Services Cabinet Council in a process that started with a statement of the Council's mission and goals and the publication of the first FAMILIES COUNT in Delaware in the fall of 1998. The indicators are organized into the categories of

1) healthy children,
2) successful learners,
3) resourceful families,
4) nurturing families, and
5) strong and supportive communities.

FAMILIES COUNT continues to evolve as stakeholders and interested Delaware citizens review the indicators to determine if measures need to be reassessed or refined. Having high quality information to measure the status and chart the progress toward improving the lives of Delaware families is a result of the growing public demand for accountable and cost-effective services and the need for and the use of information to guide decision-making in all aspects of our state's efforts to solve our basic problems. Ultimately, this framework of indicators will help state and local policymakers gauge whether services and programs are making a difference in the outcomes for children and families.

Data are presented in a variety of displays. When possible, we compare Delaware to mid-Atlantic states and the nation. These comparisons help to determine where Delaware rates in comparison to the rest of the nation, and if progress is being made over time. In addition, we present the data by counties in order to gain better understanding of the needs in particular segments of the state. Though these data may be used to monitor change or progress, sometimes it is not easy to infer whether the trend is getting better or worse from the indicator, and the same information may be interpreted in different ways. In small states like Delaware, rates tend to vary significantly from year to year. Ranks sometimes mask very small differences among states. Positive trends and high ranks do not necessarily indicate that issues no longer need attention. Finally, we recognize that there are indicators that are not included here and should be. Some of these have been included in the report as "under construction."

Ultimately, the purpose of this book is to stimulate debate, not to end debate by providing definite answers. The best solutions to social problems will emerge from the debate, not from the data. We hope this type of information will add to the knowledge base of our social well being; guide and advance informed discussions; help us concentrate on issues that need attention; and focus on a better future for our children and families.

Healthy Children

Goal: Children are born healthy. Children will remain free of preventable diseases and disabilities, and will have social, emotional, and physical health promoting behaviors. Children born with or who develop disabilities, health, social, or emotional problems reach their full potential.

	Delaware Compared to U.S. Average	Recent Trend in Delaware
Prenatal care Percent of mothers receiving prenatal care in the first trimester of pregnancy	BETTER	GETTING BETTER
Low birth weight babies Percent of low birth weight babies	WORSE	GETTING WORSE
Infant mortality Infant mortality rate per 1,000 live births	SIMILAR	ABOUT THE SAME
Lead poisoning* Percent of children age 6 and under with blood lead levels at or over 15 mcg/dl		GETTING BETTER
Child immunizations Percent of children fully immunized by age 2	BETTER	ABOUT THE SAME
Child deaths Rate of child deaths per 100,000 children ages 1–14	BETTER	ABOUT THE SAME
Children with health care coverage Percent of children to age 18 with health care coverage	BETTER	GETTING WORSE
Substance abuse, 8th graders* Percent of participants in Delaware survey of public school eighth graders using substances (cigarettes, alcohol, marijuana) in the last 30 days		GETTING WORSE
Substance abuse, 11th graders* Percent of participants in Delaware survey of public school eighth graders using substances (cigarettes, alcohol, marijuana) in the last 30 days		ABOUT THE SAME
Sexually transmitted diseases* Percent of teens ages 15–19 with gonorrhea or primary/secondary syphilis		ABOUT THE SAME
Teen deaths Rate of teen deaths by injury, homicide, and suicide (per 100,000 teens 15–19)	BETTER	GETTING WORSE

* Data not available to indicate trend and/or U.S. comparison.

Successful Learners

Goal: Children are prepared to enter school, progress to high school graduation and make successful transitions to adulthood. Increasing percentages go on to post-secondary education. Children with developmental disabilities or specific needs reach their full potential.

Early childhood disability intervention*
Percent of children ages birth to 3 receiving early intervention services

Head Start, Early Childhood Assistance Program*
Rate of participation for eligible 4 year olds in early childhood assistance programs

Student achievement: 3rd grade reading*
Percent of third graders meeting or exceeding the reading standard

Student achievement: 5th grade reading*
Percent of third graders meeting or exceeding the reading standard

Student achievement: 8th grade reading*
Percent of third graders meeting or exceeding the reading standard

Student achievement: 10th grade reading*
Percent of third graders meeting or exceeding the reading standard

Student achievement: 3rd grade math*
Percent of third graders meeting or exceeding the math standard

Student achievement: 5th grade math*
Percent of third graders meeting or exceeding the math standard

Student achievement: 8th grade math*
Percent of third graders meeting or exceeding the math standard

Student achievement: 10th grade math*
Percent of third graders meeting or exceeding the math standard

Teens not in school, not working
Percent of teens 16–19 not attending school and not working

High school dropouts*
Percent of high school dropouts

Resourceful Families

Goal: Families have educational, housing, health care, employment, and economic resources to be self-sustaining and self-sufficient at all stages in their family life cycle.

Children in poverty
Percent of children living in poverty

One-parent households
Percent of children ages 0–17 in one-parent households

Teen births
Teen birth rate for 1,000 females age 15–17

* Data not available to indicate trend and/or U.S. comparison.

Female headed households in poverty*
Percent of families in poverty with female single head of household and children

Child support collected
Percent of amount owed child support that is paid

Risk of homelessness/Families in substandard housing*
Percent of families living in substandard housing, or at risk of becoming homeless

Lack of health care coverage
Percent of persons under age 65 who do not have health care coverage

Nurturing Families

Goal: Families will provide a nurturing environment for all members free of violence, neglect, and abuse.

Abused/neglected children*
Children with substantiated reports of abuse or neglect per 1,000 children

Children in out-of-home care*
Children in out-of-home care per 1,000 children

Juvenile delinquents in out-of-home care*
Juvenile delinquents in out-of-home care per 1,000 youth ages 10–17

Domestic violence*
Number of domestic violence reports

Strong and Supportive Communities

Goal: Communities have child care, educational systems, physical infrastructure, and employment opportunities to support a high quality of life for all community members. Communities are drug, crime, and violence free. Residents are actively involved in achieving community self-sufficiency.

Unemployment rate
Unemployment rate by race and gender

Depending on neighbors*
Percent of households at 200 percent of poverty level or below that indicate they would seek help from a neighbor

Juvenile violent crime
Juvenile violent crime arrest rate (per 1,000 youths ages 10–17)

Adult violent crime arrests*
Adult violent crime arrest rate per 1,000 adults

Adults on probation or parole*
Adults on probation or parole per 1,000 adults

Substandard housing units*
Percent of substandard housing units

Home ownership
Percent of home ownership

* Data not available to indicate trend and/or U.S. comparison.

Healthy Children

Goal: Children are born healthy. Children will remain free of preventable diseases and disabilities, and will have social, emotional, and physical health promoting behaviors. Children born with or who develop disabilities, health, social, or emotional problems reach their full potential.

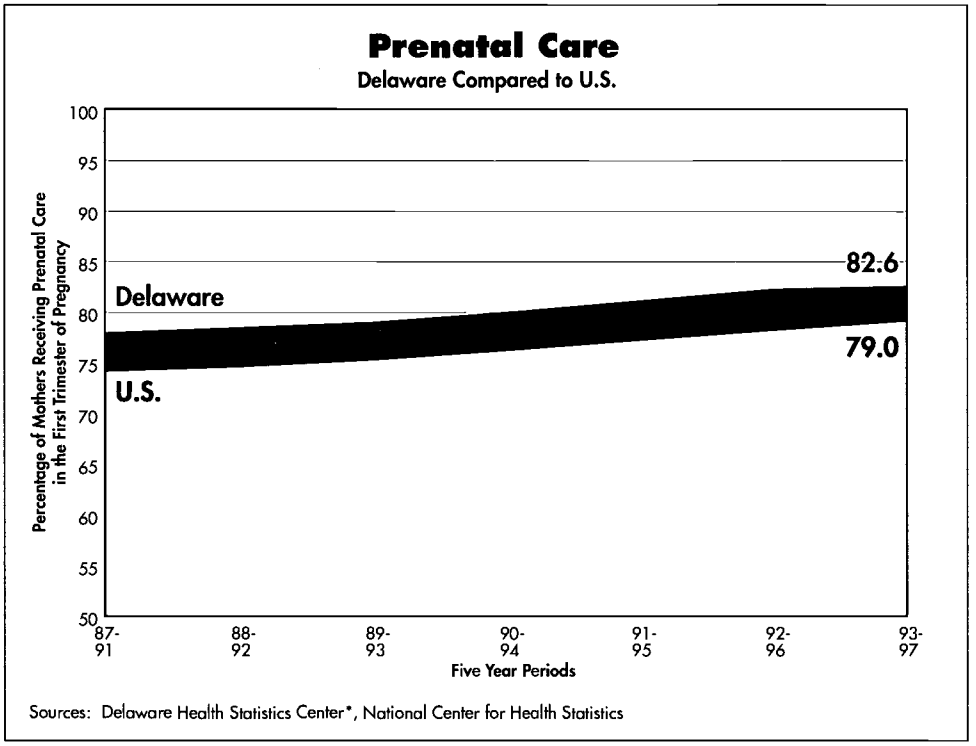
Prenatal Care

Indicator: Percent of mothers receiving prenatal care in the first trimester of pregnancy

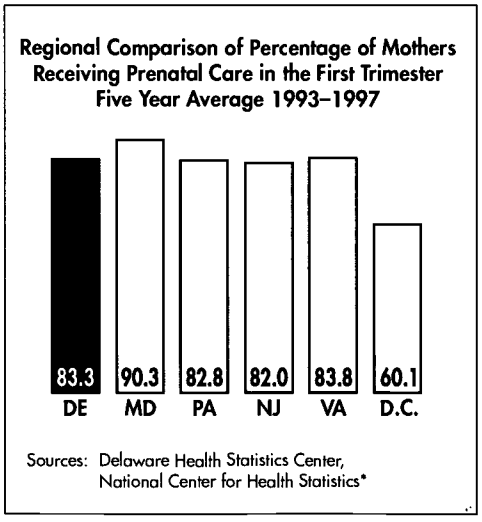
Mothers who fail to receive early prenatal care and regular prenatal care are at higher risk of delivering low birthweight infants and having their infants die before their first birthday.[1] Nearly 80 percent of women at risk for having a low birthweight baby can be identified during the first prenatal visit.[2] Early and continuous prenatal care is one of the most effective strategies for ensuring the birth of a healthy baby. Inadequate prenatal care can lead to increased costs from extended hospital stays and medical treatment for critically ill babies, lifetime medical care, and special services for children with developmental problems caused by low birthweight.[1]

1 Prenatal Care. (1999). *Michigan 1999 Databook.*

2 Something to Think About. Section for Maternal and Child Health. American Hospital Association. December 1992, p. 3



Sources: Delaware Health Statistics Center*, National Center for Health Statistics



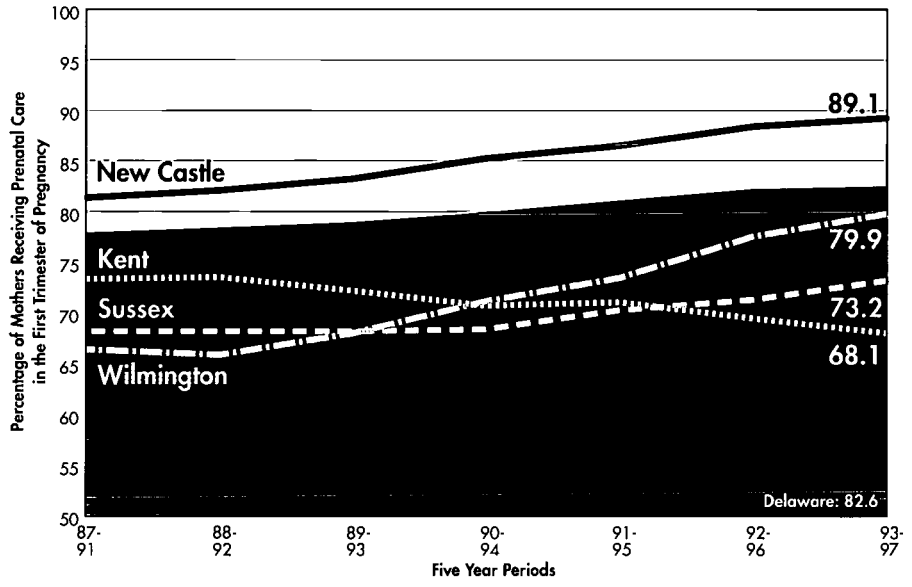
Sources: Delaware Health Statistics Center, National Center for Health Statistics*

Program Statement: Delaware has expanded Medicaid to more pregnant women than ever before, including low-income working women. An eligible pregnant woman can be immediately enrolled in Medicaid, with verification of pregnancy, enabling her to begin prenatal care without the usual waiting period.

* Percentages vary due to different estimating procedures being used by different sources.

Prenatal Care

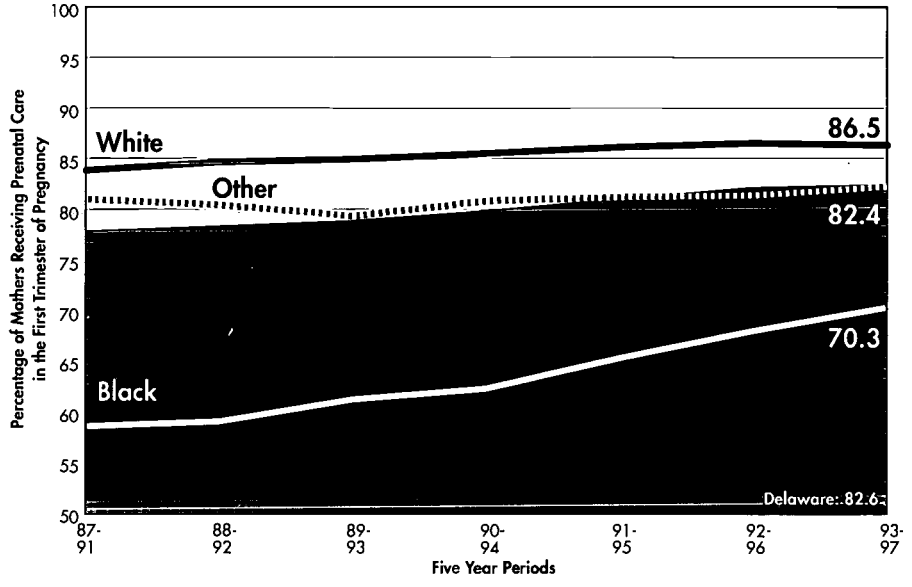
Delaware, Counties and Wilmington



Source: Delaware Health Statistics Center

Prenatal Care

Delaware by Race



Source: Delaware Health Statistics Center

For more information see

Low Birth Weight Babies p. F-12

In the KIDS COUNT Section:

Low Birth Weight Babies p. K-20

Infant Deaths by Adequacy of Prenatal Care p. K-23

Tables 9-17 p. K-58-63

Low Birth Weight Babies

Indicator: Percent of low birth weight babies

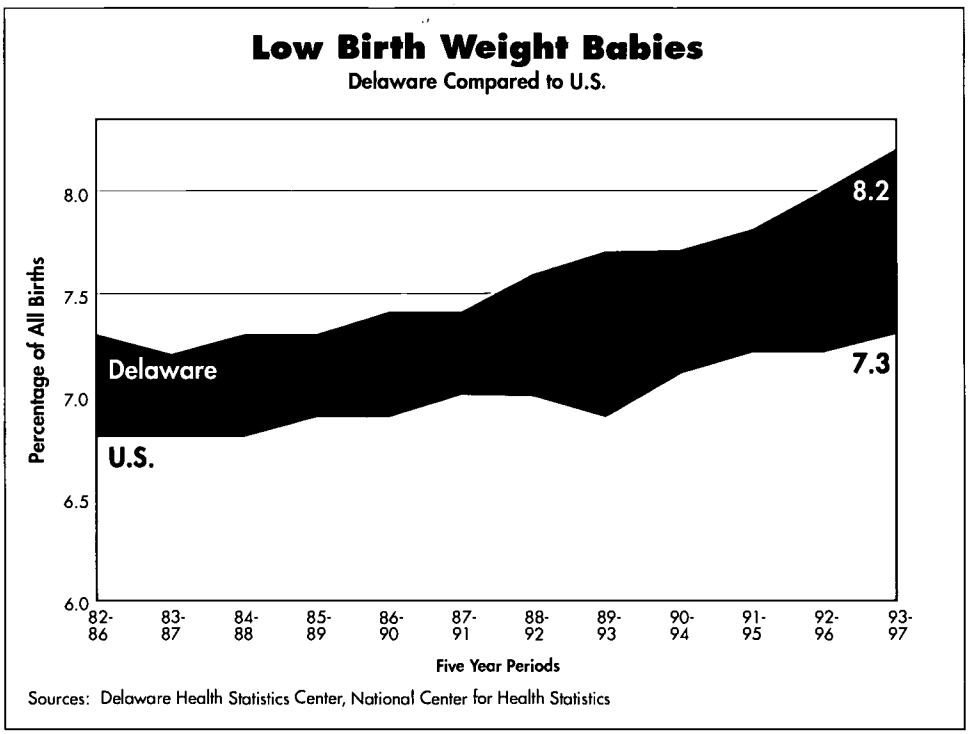
Low birth weight is defined as an infant being born at or below 2,500 grams (about 5.5 pounds). While low birth weight births account for only 4 to 5 percent of births among women of high socioeconomic status, 10 to 15 percent of the births to women in a lower socioeconomic status are born at low birth weight [1]. Risk factors associated with low birth weight include poor prenatal habits, in particular alcohol or tobacco use during pregnancy. Maternal age and mother's level of education are also correlated with low birth weight [2]. Additionally, there also seems to be racial variation in low birth weight birth rates due to an unexplained higher rate of pre-term delivery in the African American population [3].

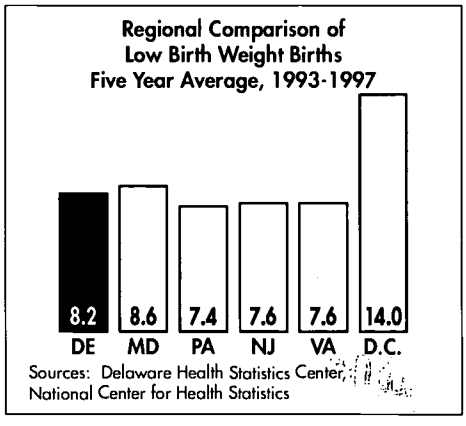
Low birth rate is a reliable predictor of infant mortality. It is associated with prolonged hospitalizations and persistent health problems. Children born at a low birth weight are at risk for developmental delays and disabilities. Many also have major birth defects.

1 Childhood diseases and disorders: disorders present at birth: prematurely and low birth weight. *Britannia Online.* Available <http://www.eb.com:180/cgi-bin?DocF=macro/5001/23/6.html>.

2 Abel, M. H. (1997, December). Low birth weight and interactions between traditional risk factors. *Journal of Genetic Psychology, 158* (4), 443-456.

3 Paneth, N. (1995, Spring). The Problem of low birthweight. *The Future of Children: Low Birthweight, 5* (1).

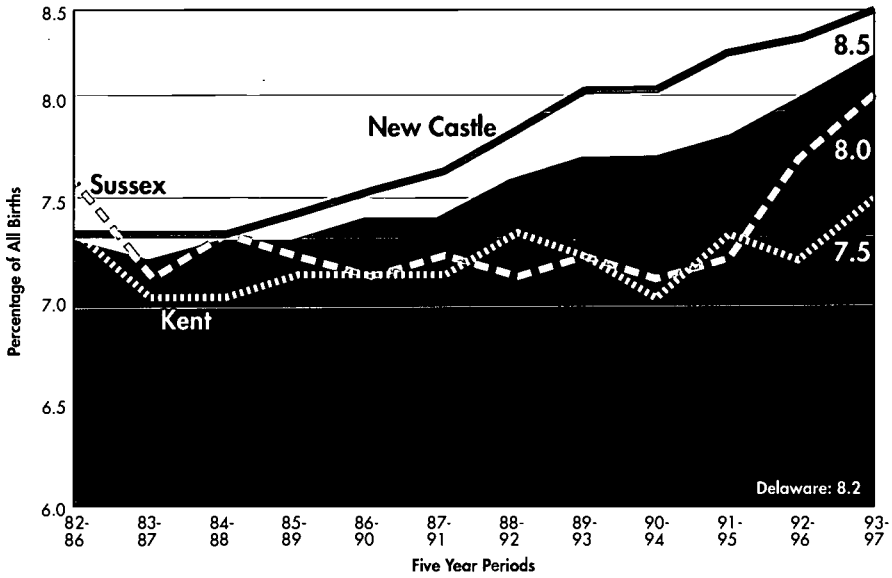




Program Statement: Having a healthy baby requires more than medical care. Medicaid provides Delaware women with high-risk pregnancies access to comprehensive services tailored to their needs. These services include medical care, nutritional services, housing, counseling, or other needed services.

Low Birth Weight Babies

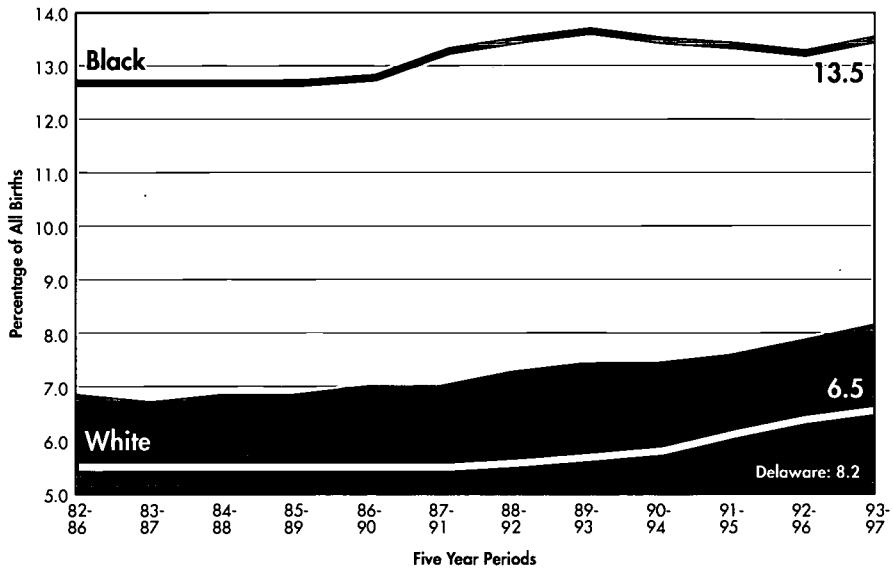
Delaware and Counties



Source: Delaware Health Statistics Center

Low Birth Weight Babies

Delaware by Race



Source: Delaware Health Statistics Center

For more information see

Prenatal Care p. F-10

In the KIDS COUNT Section:

Infant Deaths by Birth Weight of Infant p. K-23

Health problems in low-income children p. K-35

Tables 9-17 p. K-58-63

Tables 20-21 p. K-65-66

Infant Mortality

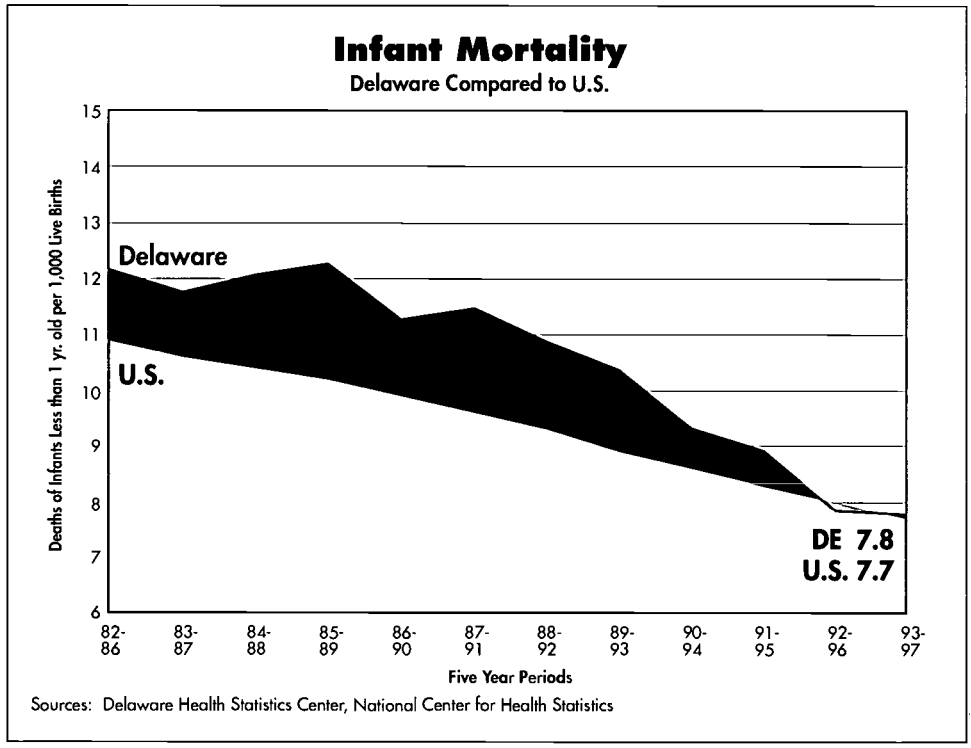
Indicator: Infant mortality rate per 1,000 births

While the infant mortality rate in the United States (and in Delaware) has continued to decline, the U.S. ranks 21st among industrialized nations in infant mortality rates[1]. The infant mortality rate measures the death of infants before their first birthday. There are conditions that increase risk of infant mortality. These include maternal age (less than 19 or over 40), timing of pregnancies (less than two years between births), poor maternal health or nutrition, race, and inadequate prenatal care[2]. Infant mortality rates tend to be related to social and economic conditions in a community. Less advantaged communities including those with poor housing, persistent poverty, and high unemployment rates tend to have higher infant mortality rates than communities without such problems[3].

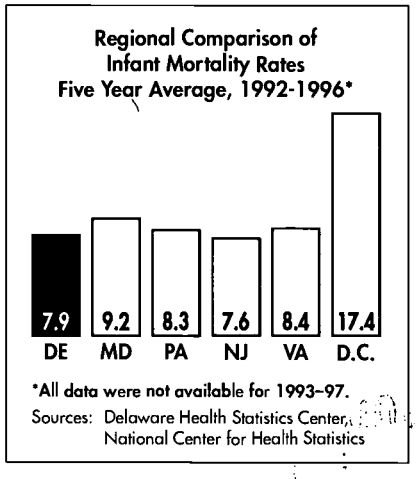
1 Infant mortality: the bad news... and the good. (1997, April). *Consultant, 37* (4), 1092.

2 Infant mortality rate. (1996). *1996 KIDS COUNT Data Book on Louisiana's Children.*

3 Infant mortality: significance. (1997). *1997 Rhode Island KIDS COUNT Factbook.*



Sources: Delaware Health Statistics Center, National Center for Health Statistics

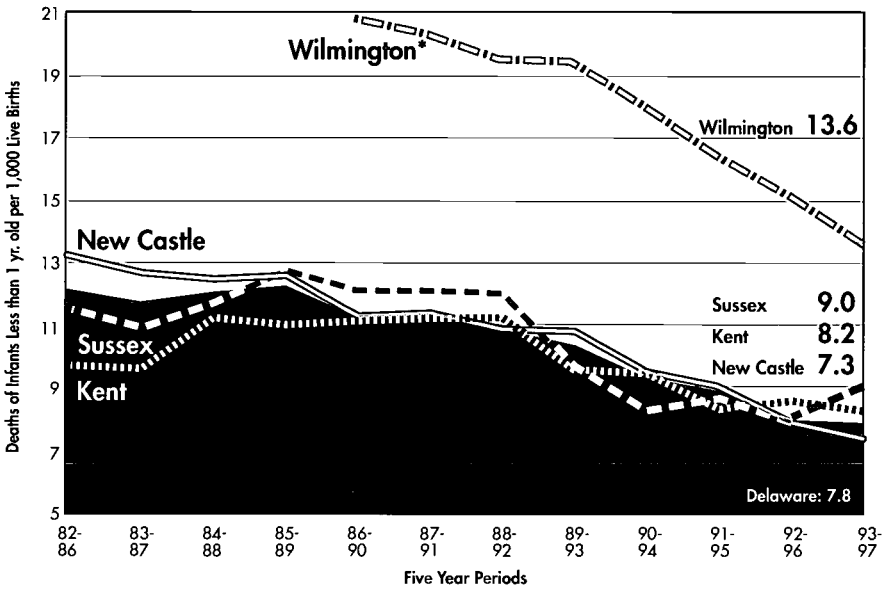


Sources: Delaware Health Statistics Center, National Center for Health Statistics

Program Statement: By providing medical and social services during pregnancy and after a baby is born, Delaware continues to reduce infant deaths. Through the Home Visiting Program, all first time parents are offered in-home support and referrals for needed services. In addition, the Perinatal Board has assumed statewide leadership to save babies' lives by examining the causes of infant mortality and providing information that promotes healthy family behavior through community outreach projects. In concert with these efforts, the Division of Public Health works to prevent Sudden Infant Death Syndrome (SIDS) through the "Back to Sleep" campaign, which promotes healthy sleeping positions for infants.

Infant Mortality

Delaware, Counties and Wilmington

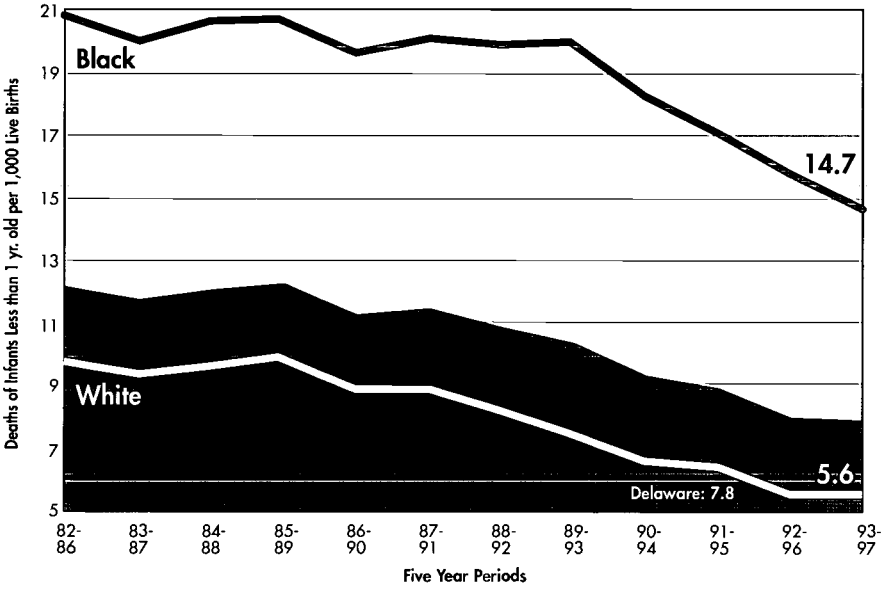


* Wilmington data not available before the 1986–1990 period.

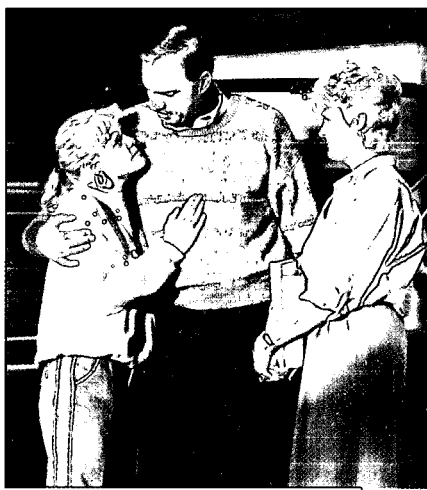
Source: Delaware Health Statistics Center

Infant Mortality

Delaware by Race



Source: Delaware Health Statistics Center



For more information see

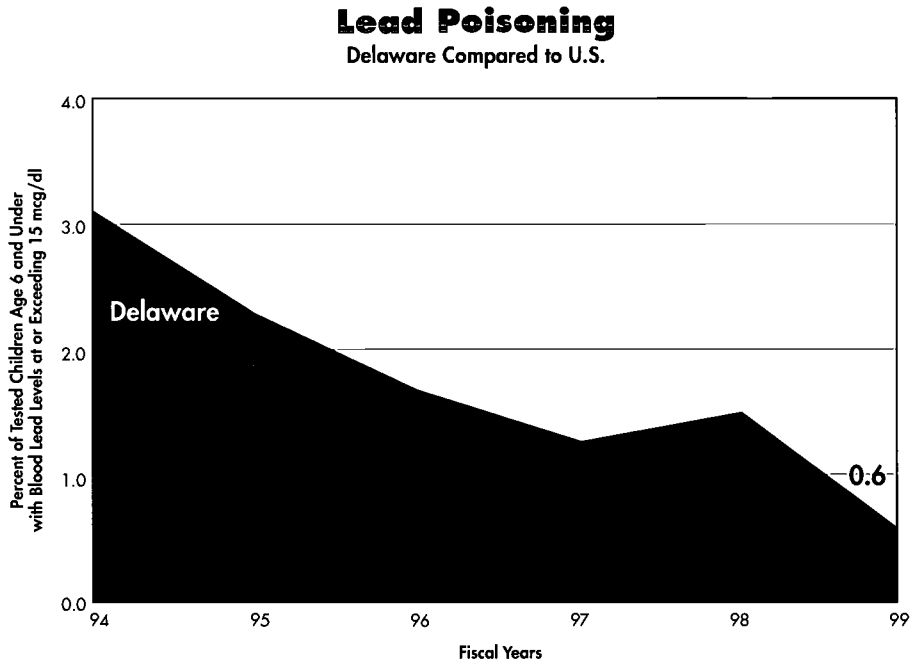
Lead Poisoning

Indicator: Percent of children age 6 and under with blood lead levels at or exceeding 15 mcg/dl

Children under the age of three are at particular risk of lead poisoning because of their rapidly developing nervous systems and their tendencies to put their hands and toys in their mouths. Since children exhibit few symptoms even with relatively high levels of lead in their systems, a blood test is the only reliable way to ascertain the level of lead in a child's body.[1] For children at risk for lead exposure the blood test can prevent a lifetime spoiled by the irreversible damage caused by lead poisoning. According to recent Center for Disease Control and Prevention estimates, 890,000 U.S. children age 1–5 have elevated blood lead levels. These figures reflect two major sources of lead exposure: deteriorated paint in older housing and dust and soil that are contaminated with lead from old paint and from past emissions of leaded gasoline.[2]

1 Lead poisoning. (1999). Michigan *Kids Count 1999 Databook*

2 Centers for Disease Control and Prevention, *Childhood Lead Poisoning Prevention*, www.cdc.gov



* U.S. data only available for 1995 from the Third National Health and Nutrition Examination Survey (NHANES III) 1991-95

Source: Delaware Department of Health and Social Services

Program Statement: Increasing awareness of childhood lead poisoning is a priority in Delaware. The Division of Public Health sends letters to doctors and nurses to remind them that Delaware law requires **all** children to be screened at or around twelve months of age. The Division also works with community agencies to reduce lead-based hazards from homes where young children reside.

For more information see

In the KIDS COUNT Section

alth Problems
ow-income Children p. K-35
Table 69 p. K-87

Child Immunizations

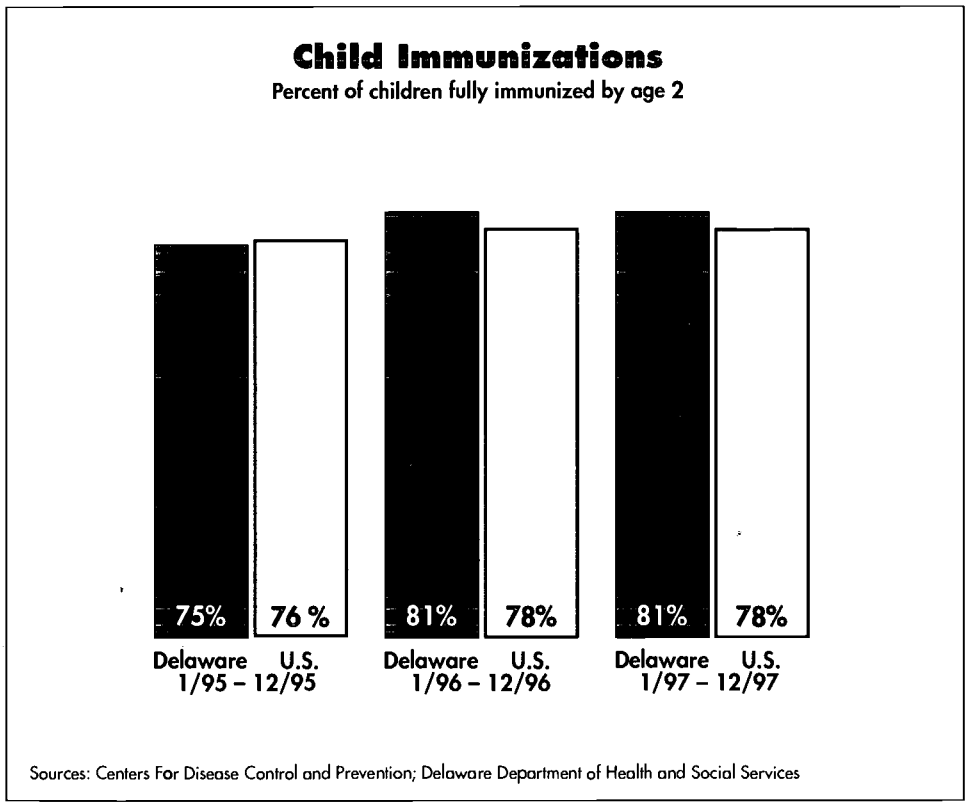
Indicator: Percent of children fully immunized by age 2

Adequate immunization protects children against several diseases that have killed or disabled many children in past decades.[1] Childhood vaccines prevent ten infectious diseases: polio, measles, diphtheria, mumps, pertussis (whooping cough), rubella (German measles), tetanus, Haemophilus influenza type-b (a cause of spinal meningitis), varicella (chicken pox), and hepatitis-B2. It is important that children receive vaccinations because of their likely exposure to infectious disease in day care settings and elsewhere.[2] Immunizations are required for school entry. Therefore most children in the U.S. have been immunized.[3]

1 America's Children: Indicators of Children Well-Being, 1999.

2 Center for Disease Control, Division of Media Relations. (1997, July 24). *Facts about the childhood immunization initiative: fact sheet.* Available http://www.cdc.gov

3 The National Education Goals Panel. (1997, October). Immunizations. *Special Early Childhood Report 1997.*



Program Statement: Delaware works toward immunizing all children. Through the Vaccines for Children program, eligible children receive free immunizations through their own medical providers. Children must also be fully immunized for families to receive full welfare benefits.

For more information see

Health Care Coverage (children)	p. F-19
Health Care Coverage (families)	p. F-41
In the KIDS COUNT Section:	
Child without Health Insurance	p. K-44
Health Problems in Low-income Children	p. K-35
Table 68	p. K-87

Child Deaths

Indicator: Rate of child deaths per 100,000 ages 1–14

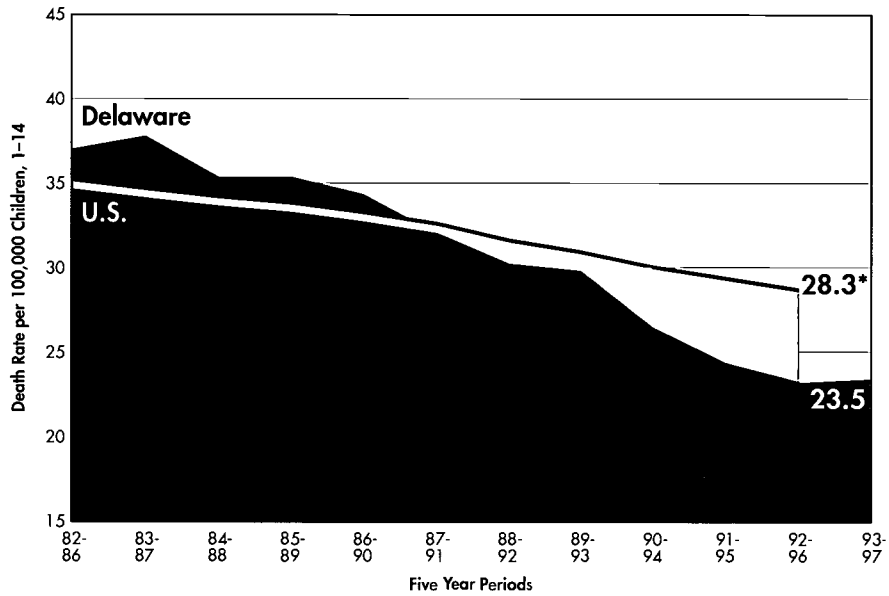
Child death rate is defined as the number of deaths per 100,000 children divided by age groups: 1 to 4 and 5 to 14. The Child Death Rate reflects risks that are fatal to children including poverty, lack of education, inadequate prenatal care, lack of health insurance, low birth weight, substandard living conditions, substance abuse, child maltreatment, and lack of adult supervision[1]. While it is estimated that 90% of unintentional injuries can be prevented, unintentional injuries remain the leading cause of death for children 1-4[2]. Injuries that do not result in death may leave children disabled, result in time lost from school, or decrease the child's ability to participate in activities[3].

1 Children's Safety Network. (1994). *Child and Adolescent Fatal Injury Data Book*. Maternal and Child Health Bureau, U.S. Department of Health and Human Services: Washington, D. C.

2 National Safe Kids Campaign. (1996). *Childhood Injury Fact Sheet*. Washington, D. C.

3 Lewit, E. M. and Baker, L. S. (1995, Spring). Unintentional injuries. *The Future of Children, 5* (1).

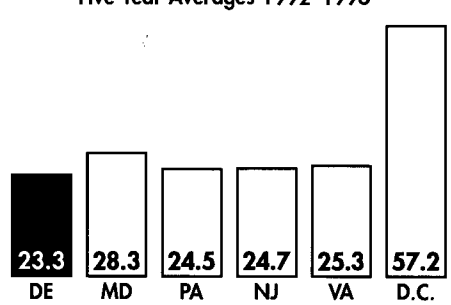
Child Deaths
Delaware Compared to U.S.



Sources: Delaware Health Statistics Center, National Center for Health Statistics

* U.S. data not available for the 1993–97 periods.

Regional Comparison of Child Mortality Rates per 100,000 Children (1-14), Five Year Averages 1992–1996*



*All data were not available for 1993–97.

Sources: Delaware Health Statistics Center, National Center for Health Statistics

Program Statement:
The Child Death Review Commission reviews all child deaths that occur in Delaware to look for ways to prevent similar deaths. Based on their review, the Commission has recommended actions to reduce child deaths by reducing traumatic injuries, increasing the use of child car seats, improving seat belt use by children, and enacting tougher sentencing laws for felonies resulting in death or serious injury to a child.

For more information see

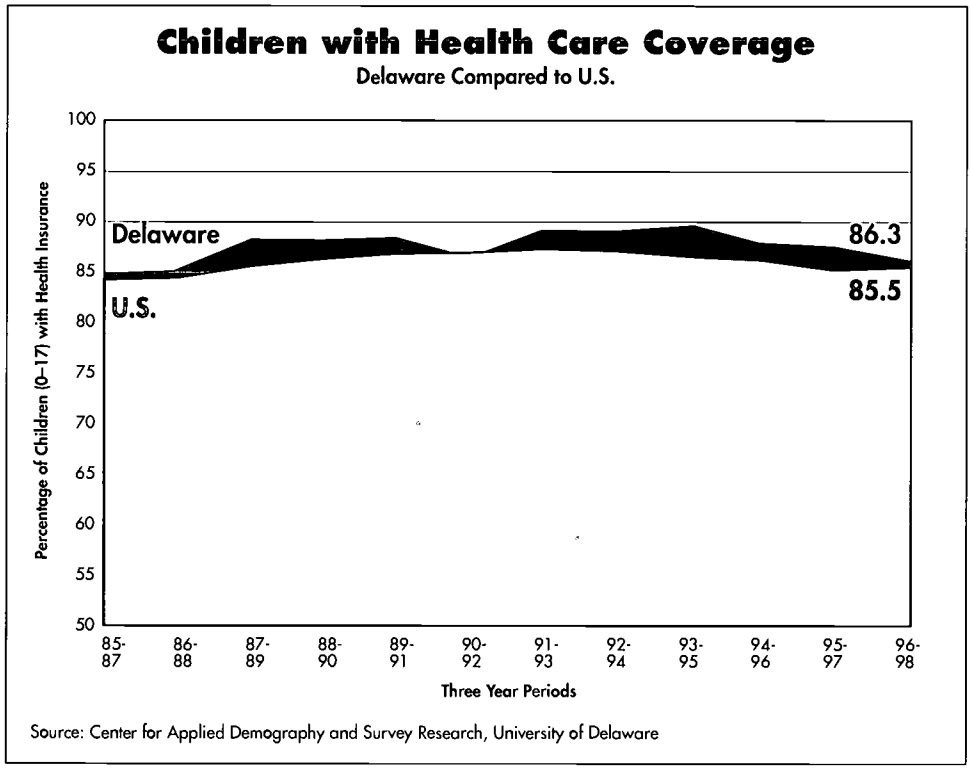
Infant Mortality	p. F-14
Teen Deaths	p. F-23
In the KIDS COUNT Section:	
Child Deaths	p. K-24
Health Problems in Law-income Children	p. K-35
Asthma	p. K-43
Child Abuse and Neglect	p. K-48
Tables 22-23	p. K-66-67
Table 66	p. K-86

Indicator: Percent of children to age 18 with health care coverage

Access to health care is an important predictor of health outcomes for children. Insured children are more likely to have a relationship with a primary care physician, to receive required preventive services, and to receive a physician's care for health problems such as asthma or ear infections[1]. Regular doctor visits are especially critical during early childhood to receive immunizations and to be screened and treated for any developmental problems[2].

1 General Accounting Office. (1997). *Health Insurance Coverage Leads to Increased Health Care Access for Children.* Washington, D. C.

2 Families USA. (1997). *Unmet Needs: The Large Differences in Health Care Between Insured and Uninsured Children.* Washington, D. C.



Source: Center for Applied Demography and Survey Research, University of Delaware

The data presented here shows the downward trend before the Delaware Healthy Children Program was instituted in January 1999. This trends illustrates the need that the program was designed to meet.

Program Statement: Delaware began expanding Medicaid coverage to all children living up to the poverty level in 1993. With the advent of the Delaware Healthy Children Program, 13,000 uninsured children in families with incomes up to twice the poverty level have access to health insurance at minimal cost. These programs, plus private insurance give 96% of Delaware's children access to health insurance.

For more information see

Health Care Coverage (Families) p. F-41

In the KIDS COUNT Section:

Asthma p. K-43

Children without Health Insurance p. K-44

Tables 51-52 p. K-80

Substance Abuse

Indicator: Percent of participants in Delaware surveys of public school 8th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days

Youth who abuse drugs and alcohol are more likely to drop out of school, become teen parents, engage in high risk sexual behavior, experience injuries, and become involved with the criminal justice system[1]. Over 90% of public school 8th graders report having had some drug education in school, yet only 24% of the same students think there is a great risk from daily drinking[2]. Regardless of age, gender, family income, and race or ethnicity, adolescents who do not live with two biological parents are 50-150% more likely than other adolescents to use illicit drugs, alcohol, or cigarettes, to be dependent on substances, or to report problems associated with use[3]. If parents or siblings smoke cigarettes, 8th grade students are likely to smoke cigarettes and use other drugs[2].

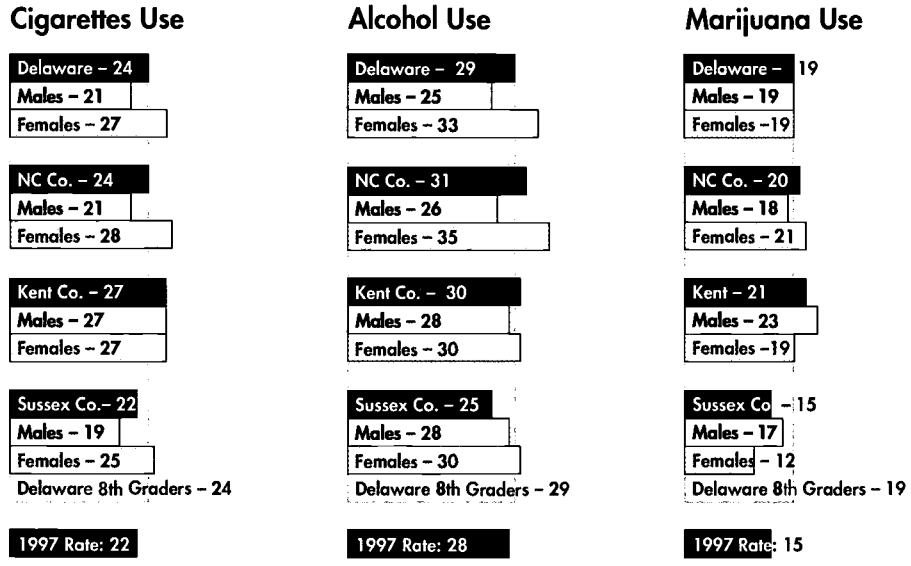
1 The Alan Guttmacher Institute. (1994). *Sex and America's Teenagers.* New York.

2 The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families. (1997, December). *Alcohol, Tobacco, and Other Drug Abuse among Delaware students, 1997.*

2 Children's Defense Fund. (1995). *State of America's Children Yearbook 1995.* Washington, D. C.

Substance Abuse

Percent of participants in Delaware surveys of public school 8th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days Delaware, 1998



Sources: The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families

Program Statement: The Department of Education has primary responsibility for funds received under the Safe and Drug Free Schools and Communities Act. Grants to school districts support a range of skill-based programs and intervention strategies such as conflict resolution training and substance awareness. DOE also works collaboratively with the Office of Prevention at the Department of Services for Children, Youth and Their Families – Family Services Division, and the University of Delaware on substance abuse issues.

For more information see

Substance Abuse – 11th Grade p. F-21

Student Achievement p. F-28

In the KIDS COUNT Section:

Alcohol, Tobacco, and Other Drugs p. K-46

lent Violence Possession p. K-33

es 30-36 p. K-70-73

Indicator: Percent of participants in Delaware surveys of public school 11th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days

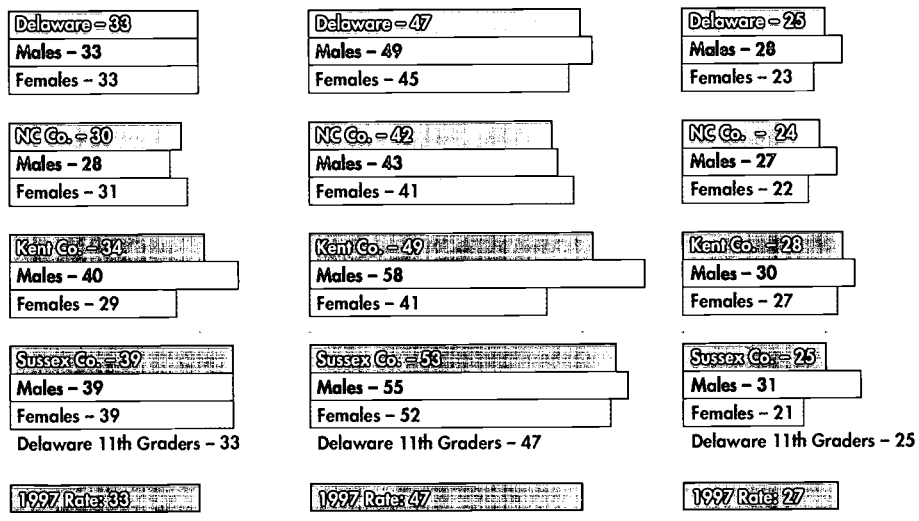
Research shows that alcohol is the drug most frequently used by 12–17 year olds and that alcohol-related car crashes are the number one killer of teens.[1] Binge drinking (defined here as three or more drinks at a time in the past two weeks) is quite high among the surveyed 11th graders. Most students who report having at least one drink in the past month also report binge drinking in the past two weeks. Thirty percent of all public school 11th graders report binge drinking.[2]

1 Kansas Action for Children. (1997). *Kansas KIDS COUNT 1997 Data Book.*

2 The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families. (1997, December). *Alcohol, Tobacco, and Other Drug Abuse among Delaware students, 1997.*

Substance Abuse

Percent of participants in Delaware surveys of public school 11th graders using substances (cigarettes, alcohol, marijuana) in the last 30 days Delaware, 1998



Sources: The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families

For more information see

Substance Abuse – 8th Grade p. F-20

Student Achievement p. F-28

In the KIDS COUNT Section:

Alcohol, Tobacco, and Other Drugs p. K-46

Student Violence and Possession p. K-33

Tables 30-36 p. K-70-73

Sexually Transmitted Diseases

Indicator: Percent of teens age 15-19 with gonorrhea or primary/secondary syphilis

According to the Centers for Disease Control and Prevention, the U.S. has one of the highest rates (of industrialized nations) for sexually transmitted diseases (STDs) with people under twenty-five accounting for nearly two-thirds of all reported cases. One out of every six teenagers (age 13-19) become infected each year[1]. Ignorance about STDs is a growing problem among adolescents; in one American Social Health Association study, only 33% of teenagers could name a single STD[2].

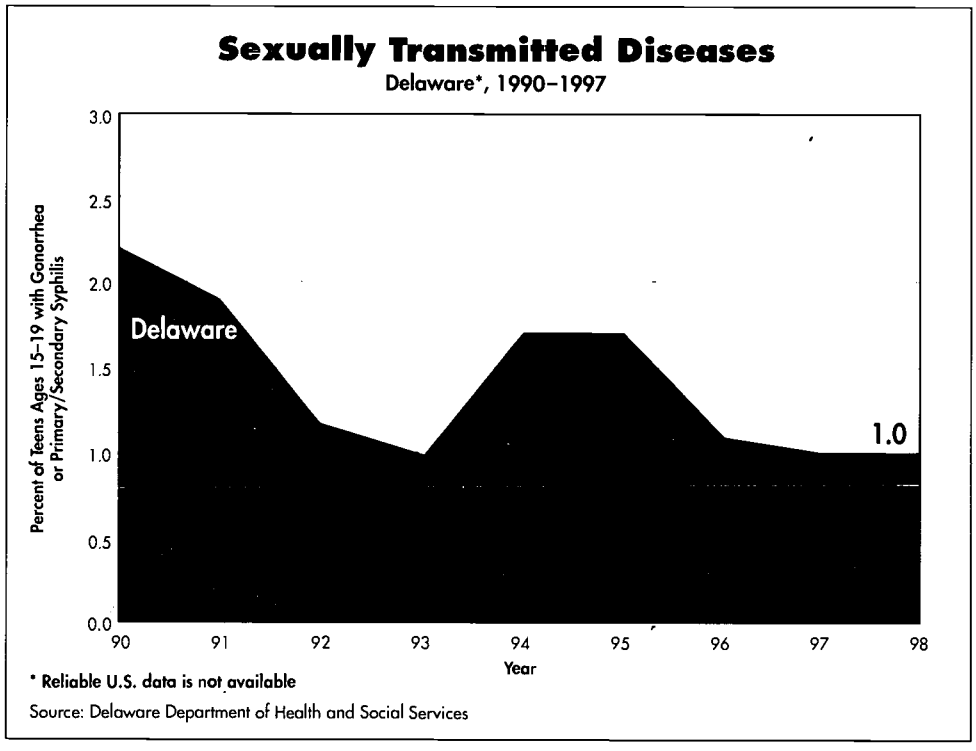
Gonorrhea is spread through unprotected sexual intercourse. While the disease is treatable with antibiotics, if gone unnoticed, gonorrhea can result in pelvic inflammatory disease, infertility, ectopic or tubal pregnancies, or can spread to the blood or the joints. Gonorrhea also increases the risk of HIV infection[3]. Syphilis is also spread through unprotected sexual intercourse. Once recognized, syphilis is easily and completely curable with antibiotics. The open sores (chancres) which characterize the primary stage of syphilis increase one's risk of contracting the HIV virus[4].

1 Sexually transmitted disease and adolescents. (1996, April). *State Legislature, 22* (4), 7.

2 MacPherson, P. (1996, March). In the dark about safe sex. *Hospitals and Health Networks, 70* (5), 42.

3 Office of Communications, National Institute of Allergy and Infectious Diseases, National Institute of Health, U.S. Department of Health and Human Services. (1998, June). Gonorrhea fact sheet. Available <http://www.niaid.nih.gov/factsheets/stdgon.htm>

4 Syphilis. *The STD Homepage.* Available <http://med-www.bu.edu/people/sycamore/std/syphilis.htm>



Program Statement: Delaware strives to prevent high risk behaviors that lead to teen pregnancy and sexually transmitted diseases (STDs). As part of broad-based strategies to reduce risky behavior, any teen can receive basic contraceptive and disease prevention counseling when seen in STD or family planning clinics statewide, where free condoms are also available.

For more information see
e KIDS COUNT Section:
e 70 p. K-87

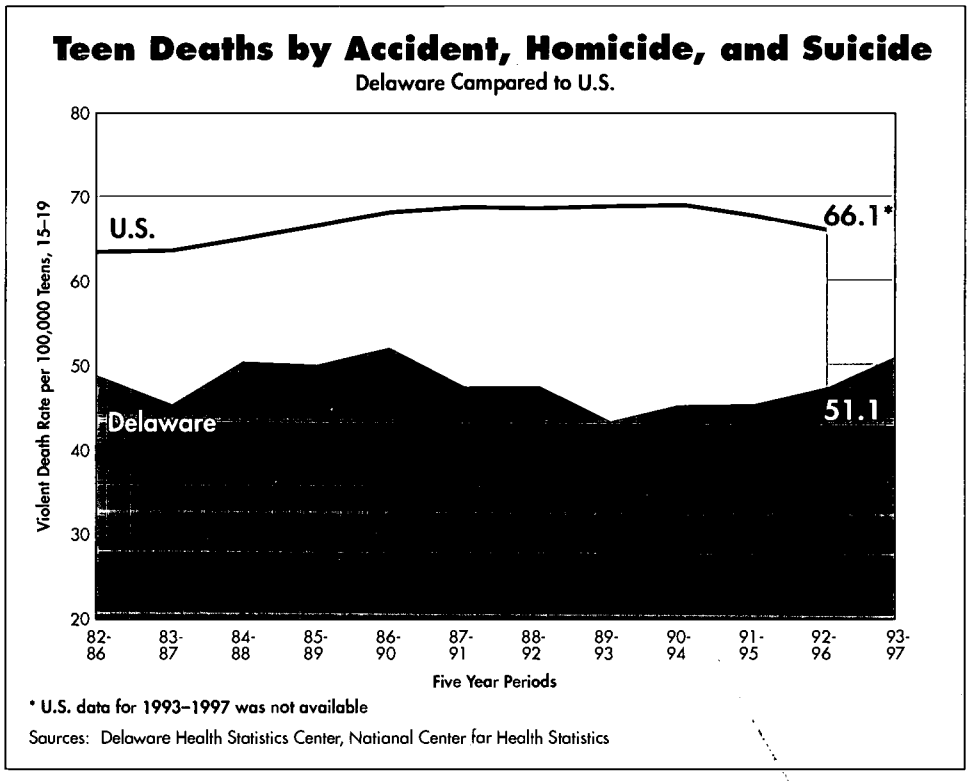
Indicator: Rate of teen deaths by injury, homicide, and suicide (per 100,000 teens age 15–19)

Research shows that poverty, the increased availability of handguns, and the rise in gang activity are all risk factors associated with teen violent death[1]. Homicide and violence generally indicate delinquency, hostility, and anger and can be an indicator of community safety. Suicide is an indicator of stress, mental health, community support, and family support[2]. Compared with younger children, teens have a much higher rate of death from motor vehicle crashes and firearm related injuries[3].

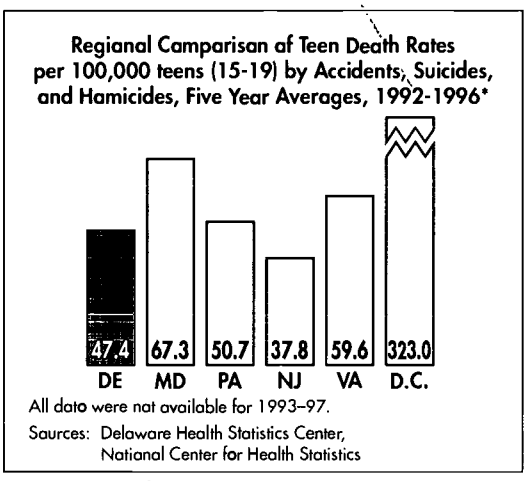
1 Children's Safety Network. (1994). *Firearm facts: information on gun violence and its prevention*. Maternal and Child Health Bureau, U.S. Department of Health and Human Services: Washington, D. C.

2 Pennsylvania KIDS COUNT Partnership. (1995). *The State of the Child in Pennsylvania*.

3 Fingerhut, L. A., Annest, J. L., Baker, S. P., Kochanek, K. D., and McLaughlin, E. (1996). Injury mortality among children and teenagers in the United States, 1993. *Injury Prevention*.



Program Statement: Prevention activities are offered to teens where they are-in schools and communities. School-based health center programs targeted to prevent deaths among teens include suicide prevention, alcohol and drug abuse prevention, violence prevention and conflict resolution, and counseling. Delaware's Family Service Cabinet Council coordinates many community-based prevention programs, including Family Service Partnerships, Strong Communities projects, and Prevention Networks.



For more information see

Substance Abuse	p. F-20-21
In the KIDS COUNT Section:	
Teen Deaths	p. K-26
Alcohol, Tobacco, and Other Drugs	p. K-46
Table 24-25	p. K-68
Table 30-32	p. K-70-71

Successful Learners

Goal: Children are prepared to enter school, progress to high school graduation and make successful transitions to adulthood. Increasing percentages go on to post-secondary education. Children with developmental disabilities or specific needs reach their full potentials.

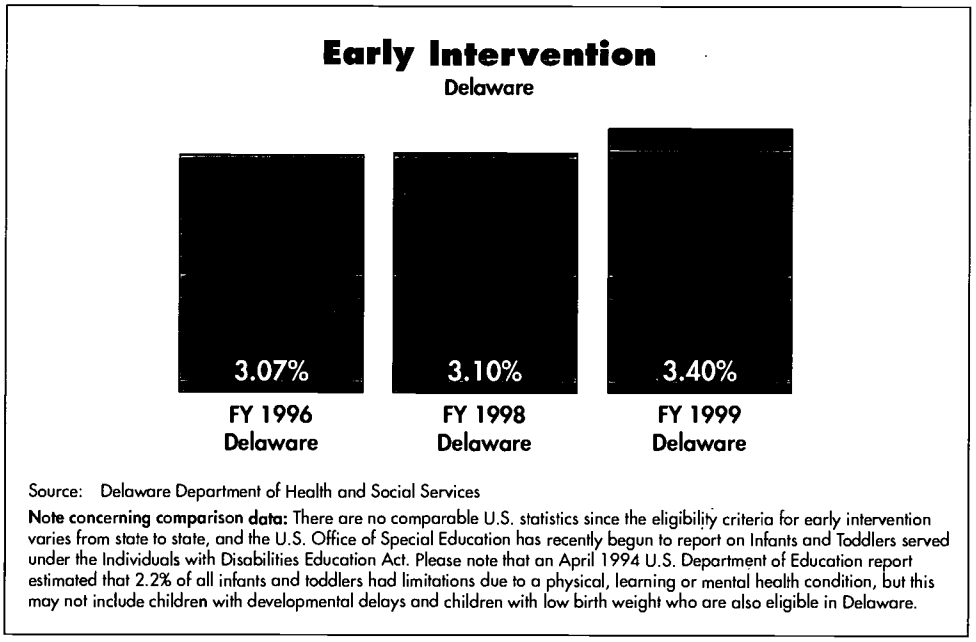
Early Intervention

Indicator: Percent of children ages birth to three receiving early intervention developmental disability services

Children with disabilities are an extremely heterogeneous group, varying by type of disability and age of the child, as well as by the many differences in the population at large—such as family income and demographics. While there are wide variations in the specific needs of each child, there are some issues of common concern to families of children with disabilities[1]. Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, parent support, child care, recreation, and career preparation[2].

1 The David and Lucile Packard Foundation. (1996). Special education for students with disabilities. *Special Education for Students with Disabilities.* Los Altos, CA: Center for the Future of Children.

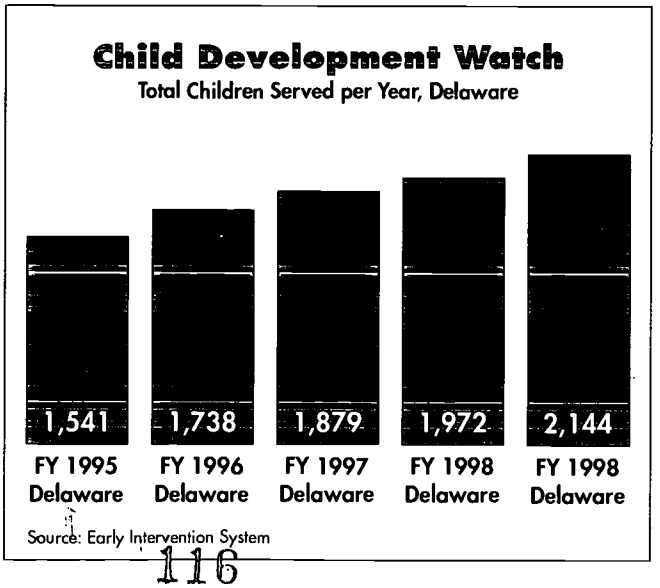
2 Martin, E. W., Martin, R. and Terman, D. L.; The David and Lucile Packard Foundation. (1996). The legislative and litigation history of special education. *Special Education for Students with Disabilities.* Los Altos, CA: Center for the Future of Children.



Source: Delaware Department of Health and Social Services

Note concerning comparison data: There are no comparable U.S. statistics since the eligibility criteria for early intervention varies from state to state, and the U.S. Office of Special Education has recently begun to report on Infants and Toddlers served under the Individuals with Disabilities Education Act. Please note that an April 1994 U.S. Department of Education report estimated that 2.2% of all infants and toddlers had limitations due to a physical, learning or mental health condition, but this may not include children with developmental delays and children with low birth weight who are also eligible in Delaware.

Program Statement:
Delaware provides extra help to infants and toddlers who need it. Child Development Watch (CDW) partners with families to serve children ages birth to three with disabilities and developmental delays. Through individualized service plans, CDW provides access to needed services, such as physical, occupational, and speech-language therapy, family training and counseling, and transportation.



Source: Early Intervention System

For more information see

Head Start and Early Childhood Assistance Program p. F-27

the KIDS COUNT Section:
Early Care and Education p. K-38

Head Start and Early Childhood Assistance Program

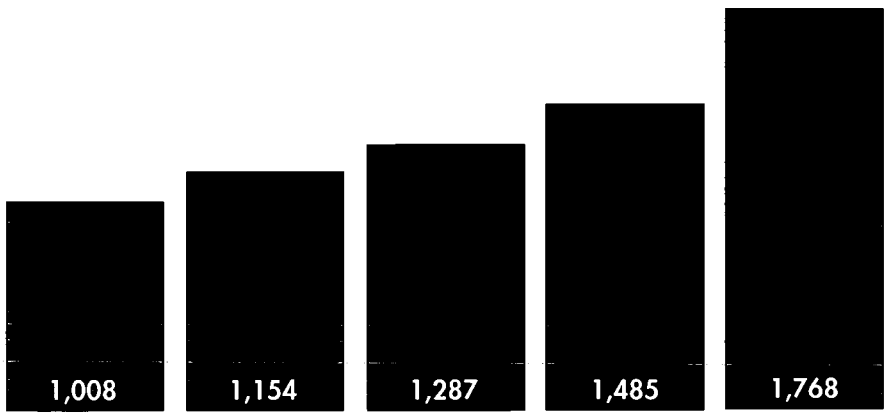
Indicator: Rate of participation for eligible 4 year olds in Head Start and Early Childhood Assistance Program

Head Start and the Early Childhood Assistance Program provide comprehensive early childhood development program for low-income preschool children and their families; most children in the program attend for one year and are four years old. The Early Childhood Assistance Program (ECAP) in Delaware provides funding for four year olds who meet eligibility criteria for Head Start programs. Head Start and ECAP program components include education, parent involvement, social services, health and nutrition, and mental health. The programs are designed to provide low-income children with the socialization and school readiness skills they need to enter public schools on an equal footing with their peers. Many factors contribute to a child's success in school. These factors are integrated within the five dimensions that embrace early development and learning that include: physical well-being and motor development, social and emotional development, approaches toward learning, language development, and cognition and general knowledge[1]. Readiness is shaped and developed by people and environments in the early childhood years.

1 National Education Goals Panel (1995). Reconsidering Children's Early Development and Learning.

Head Start/ECAP

4-Year-Old Children Served in Delaware



	94–95	95–96	96–97	97–98	98–99
Estimated number of 4-yr.-olds in Head Start	855	865	886	931	925
Number of children in ECAP	153	289	401	554	843
Estimated number of 4-yr.-olds eligible	N/A	N/A	N/A	1,938	1,938
Percentage of 4-yr.-olds served	N/A	N/A	N/A	77%	91%

Source: Delaware Department of Education

Program Statement: Delaware provides funding for comprehensive early childhood services for 4 year old children whose families are at or below 100% of poverty to complement existing Head Start programs that ensures opportunities for preschool education for all eligible children. Working collaboratively with federally-funded Head Start centers and other early care and education programs throughout the state, these Department of Education programs provide a full range of preschool, health, developmental, and other family support services.

For more information see
Head Start p. F-26
In the KIDS COUNT Section:
Early Care and Education p. K-38

Student Achievement

Indicator: Percent of third, fifth, eighth, and tenth graders at or above the standard for reading

Indicator: Percent of third, fifth, eighth, and tenth graders at or above the standard for math

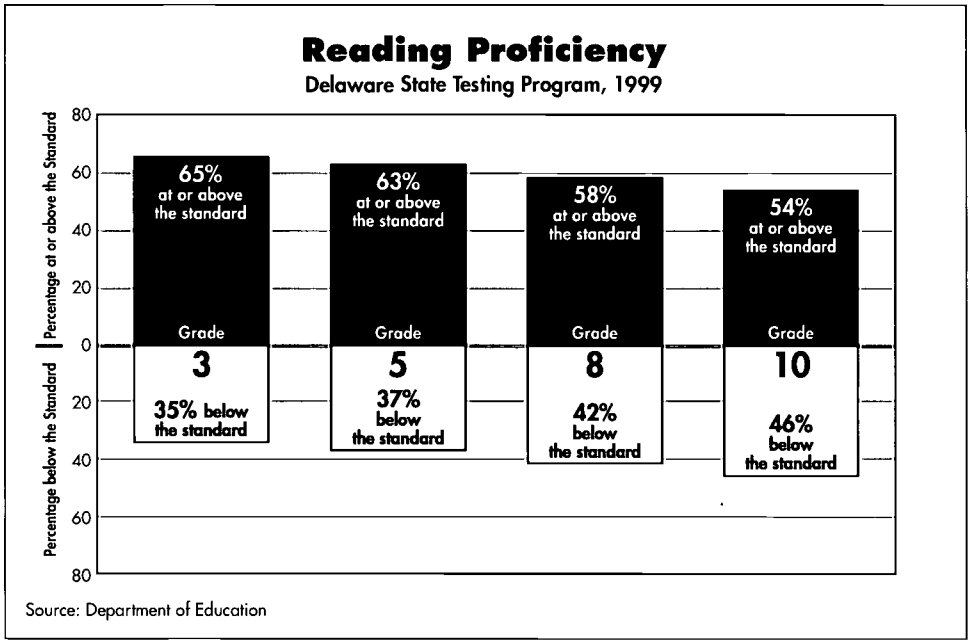
The extent and content of students' knowledge, as well as their ability to think, learn, and communicate, affect their ability to succeed in the labor market well beyond their earning of a degree or attending school for a given number of years. On average, students with high test scores will earn more and will be unemployed less often than students with lower test scores.[1] Math and reading achievement test scores are important measures of students' skills in these subject areas, as well as good indicators of achievement overall in school.[2]

1 Decker, P.T., Rice, J.K., Moore, M.T., and Rollefson, M. (1997). *Education and the economy: An indicators report.* Washington, D.C: National Center for Education Statistics.

2 Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being, 1999.* Washington, D.C..

Delaware State Testing Program

The Delaware State Testing Program (DSTP), designed by Delaware educators, measures how well students are progressing toward the state content standards. The program is one part of a much larger and richer effort by the educational community to ensure a high quality education for each and every student in Delaware. The DSTP will assist Delaware educators in determining the degree to which we are achieving the goal. The score reports from this second year of the DSTP will give each school a sense of where they stand in their efforts to help all students meet the standards.



Source: Department of Education

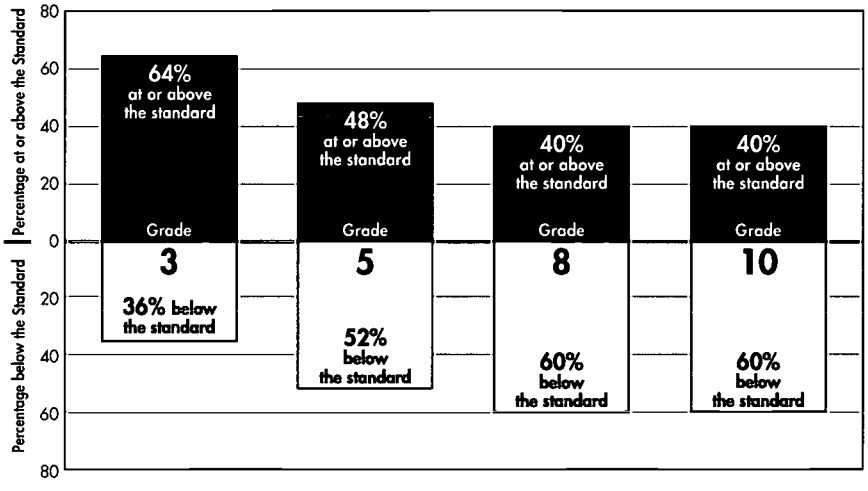
DSTP Proficiency Levels – Delaware State Testing Program, 1999

Students receive scores indicated by the following levels:

Level	Category	Description
5	Distinguished	Excellent performance
4	Exceeds the standard	Very good performance
3	Meets the standard	Good performance
2	Below the standard	Needs improvement
1	Well below the standard	Needs lots of improvement

Math Proficiency

Delaware State Testing Program, 1999



Source: Department of Education

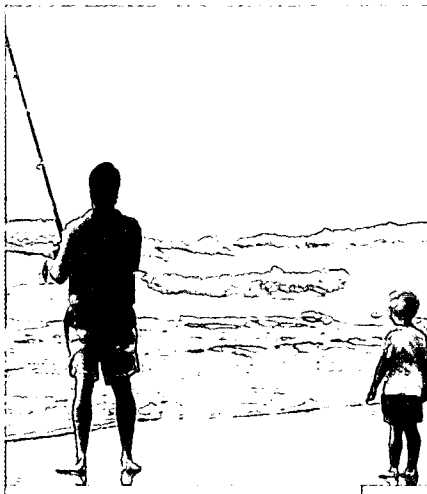
The Building Blocks of Delaware's Education Plan

1. Ensuring children enter school ready to learn
2. Requiring accountability
   - Setting high standards in core academic subjects
   - Measuring performance of schools and school districts
   - Setting standard and providing incentives for teachers to excel
3. Guaranteeing safe, disciplined schools
4. Empowering parents through school choice, charter schools, and school-based decision making
5. Equipping schools with technology to support excellence in instruction
6. Providing education and training for work and life

Guiding Principles of Delaware's Accountability Plan

The most important function of the Delaware public school system is to produce graduates with outstanding skills and knowledge in the core academic subjects – English/language arts, math, science and social studies.

- Reading is the most important learning skill. The second most important learning skill is math.
- The social promotion of students deficient in reading and math is wrong and must end.
- Students who perform well should receive recognition for high achievement.
- Delaware should provide rewards for high-performing schools and consequences for holding poorly performing schools accountable.
- New teachers should meet pre-service standards, and the performance of all teachers should be evaluated at the local level.
- Local school districts should remain primarily responsible for professional and staff development.



For more information see

High School Dropouts p. F-31

In the KIDS COUNT Section:

High School Dropouts p. K-30

Tables 39-46 p. K-75-78

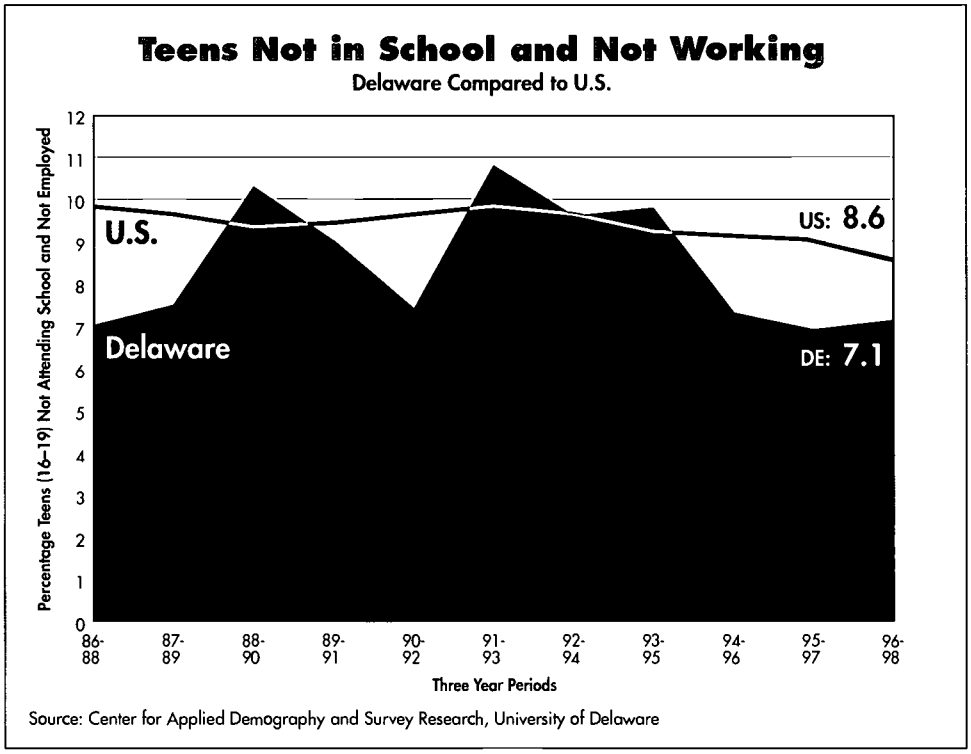
Teens Not in School and Not Working

Indicator: Percent of teens age 16–19 not attending school and not working

The indicator "teens not in school and not working" is defined as youth ages 16–19 who are not enrolled in school and are unemployed. This indicator includes recent high school graduates who are unemployed and teens who have dropped out of high school who are jobless. Teens who are not in school or working for extended periods of time become disconnected from society because they are not involved in any of the key activities that are critical to development[1]. They are at increased risk for juvenile delinquency, substance abuse, crime victimization, teenage pregnancy, and poverty. Few skills and little education present significant barriers in finding and keeping a job later in life[2].

1 Brown, B. V. (1996, March). Who are America's disconnected youth? *American Enterprise Institute.*

2 Idaho KIDS COUNT. (1996). *Idaho KIDS COUNT Data Book: 1996*, 31-32.



Source: Center for Applied Demography and Survey Research, University of Delaware

Program Statement: In partnership with the Department of Education, the Division of Vocational Rehabilitation (DVR) operates a program to reduce the number of dropouts from secondary school and to assist students with disabilities transition from school to work. Two DVR counselors work with a team in each of the nineteen districts to develop individualized educational plans for students with disabilities. Through this effort, the Division intends to increase by 10% annually, the number of students who transition from education to employment over the next three years. In addition, The Department's overall School to Work efforts include partnerships with the Delaware Technical and Community College and local school districts to develop career pathways leading to successful work experiences.

For more information see

Student Achievement	p. F-28
High School Dropouts	p. F-31
Unemployment	p. F-50
In the KIDS COUNT Section:	
High School Dropouts	p. K- 30
Teens Not in School Not Working	p. K-32
Tables 39-46	p. K-75-78
Table 61	p. K-84

High School Dropouts

Indicator: Percent of high school dropouts

Children who receive a quality education are more likely to grow into capable, self-sufficient adults who are contributing members of society. Education in this ever-changing world is critical to a young person's success in the work force[1]. College graduates today earn twice the wages of high school graduates and nearly triple the wages of a high school dropout. Those youth who do dropout have not gained skills and knowledge essential for future success[2]. They are likely to live in poverty as the jobs they are likely to hold have incomes which go down over time in comparison to inflation[3]. Early warning signs for a student likely to drop out include:

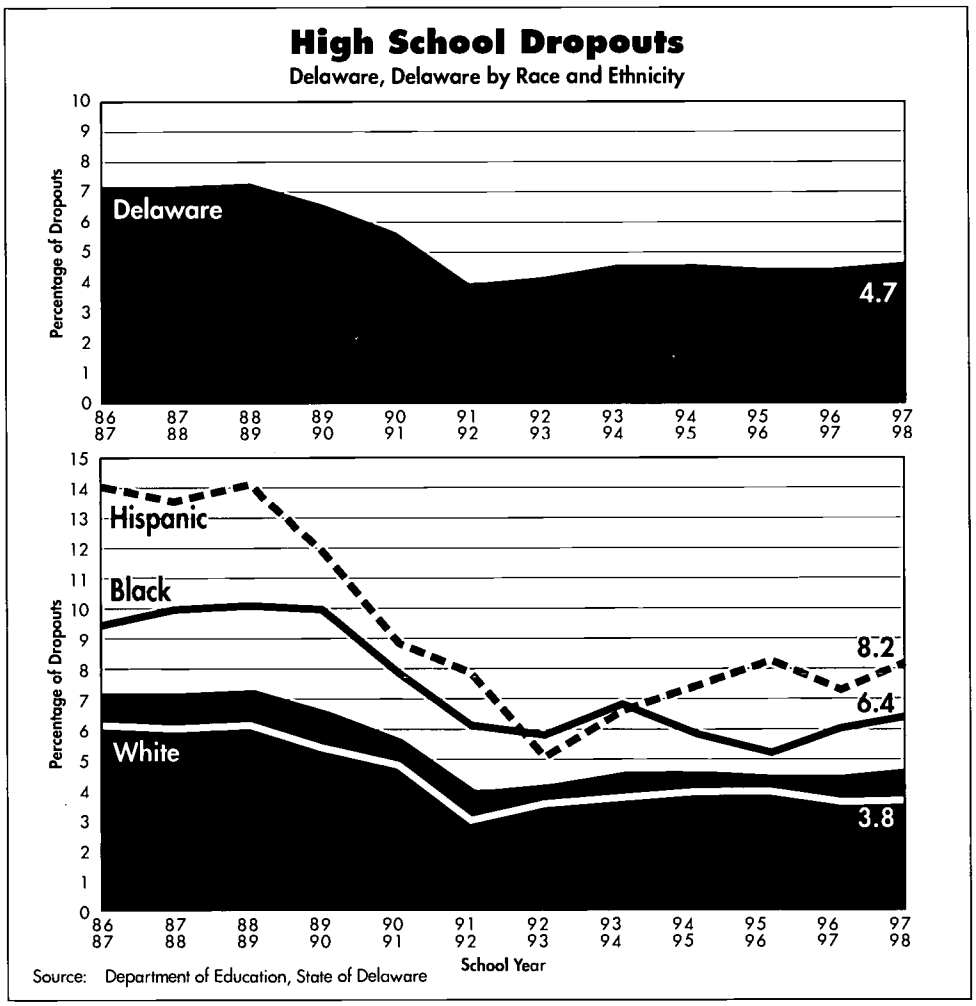
- missing or cutting class frequently
- excessive lateness to class
- inability to read at grade level
- being put on in-school suspension, suspension, or probation
- poor grades
- arrests
- substance abuse problems
- teen pregnancies or
- spending time in juvenile homes or shelters[4].

1 High school graduation rate: significance. (1997). *1997 Rhode Island KIDS COUNT.*

2 Children's Defense Fund. (1998). *The State of America's Children Yearbook 1998.* Washington D. C.

3 Remarks by President Clinton to the Delaware State Legislature. (1998, May). Dover, DE: Senate Chambers.

4 Schwartz, W. School dropouts: new information about an old problem. *ERIC Clearinghouse on Urban Education Teacher's College,* Columbia University. Available <http://www.handsnet.org>.



Source: Department of Education, State of Delaware

Program Statement: The reduction of Delaware's high school dropout rate is a strong objective of several programs supported through the Department of Education. For example, Groves Adult High School is a statewide program designed for adults and out-of-school youth that have not received a high school diploma. The state has also funded alternative programs for students who have been or are close to being expelled.

For more information see

Student Achievement	p. F-28
Teens Not in School and Not Working	p. F-30
Unemployment	p. F-50
In the KIDS COUNT Section:	
Infant Deaths by Education of Mother	p. K-23
High School Dropouts	p. K-30
Teens Not in School and Not Working	p. K-32
Suspension and Expulsions	p. K-33
Tables 39-46	p. K-75-78
Table 61	p. K-84

Resourceful Families

Goal: Families have the educational, housing, health care, employment, and economic resources to be self-sustaining and self-sufficient at all stages in their family life cycle.

Children in Poverty

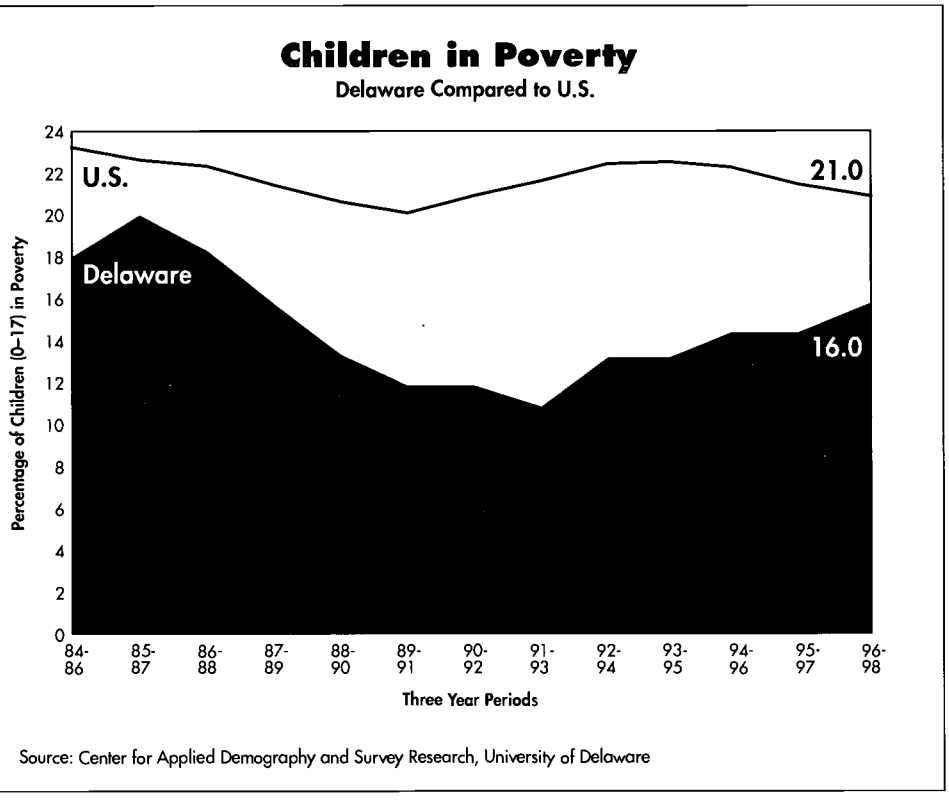
Indicator: Percent of children living in poverty

Poverty is related to all of the KIDS COUNT indicators. It is defined as the condition of not having enough income to meet basic needs for food, clothing, and shelter[1]. The 1998 poverty threshold for a family of four was $16,530 per year. Poverty affects children through inadequate nutrition, fewer learning experiences, residential instability, poor quality of schools, exposure to environmental toxins and family violence, dangerous streets, and reduced access to a support network[1]. The price of poverty is passed on to society by the effect on its schools, hospitals, and criminal justice system[2]. Poverty affects many; one third of U.S. children will be poor for at least one year of their childhood. For some, the impoverishment will stretch across childhood and reach into their adult years[3].

1 Future of children: the effects of poverty on children. (1997, Summer-Fall). *The Center of the Future of Children, 7* (2).

2 Children's Defense Fund. (1998). *The State of America's Children Yearbook 1998.* Washington D. C.

3 Future of children: dynamics of childhood poverty. (1997, Summer-Fall). *The Center of the Future of Children, 7* (2).



Source: Center for Applied Demography and Survey Research, University of Delaware

Program Statement: Delaware provides a safety net for the poor and is constantly striving to lift families out of poverty. Through Delaware's A Better Chance Welfare Reform Program, Delaware helps the parents of children in the poorest families get and keep jobs. The state also helps pay for child care, provides access to affordable health care and encourages parents to make timely child support payments.

For more information see

One-Parent Households

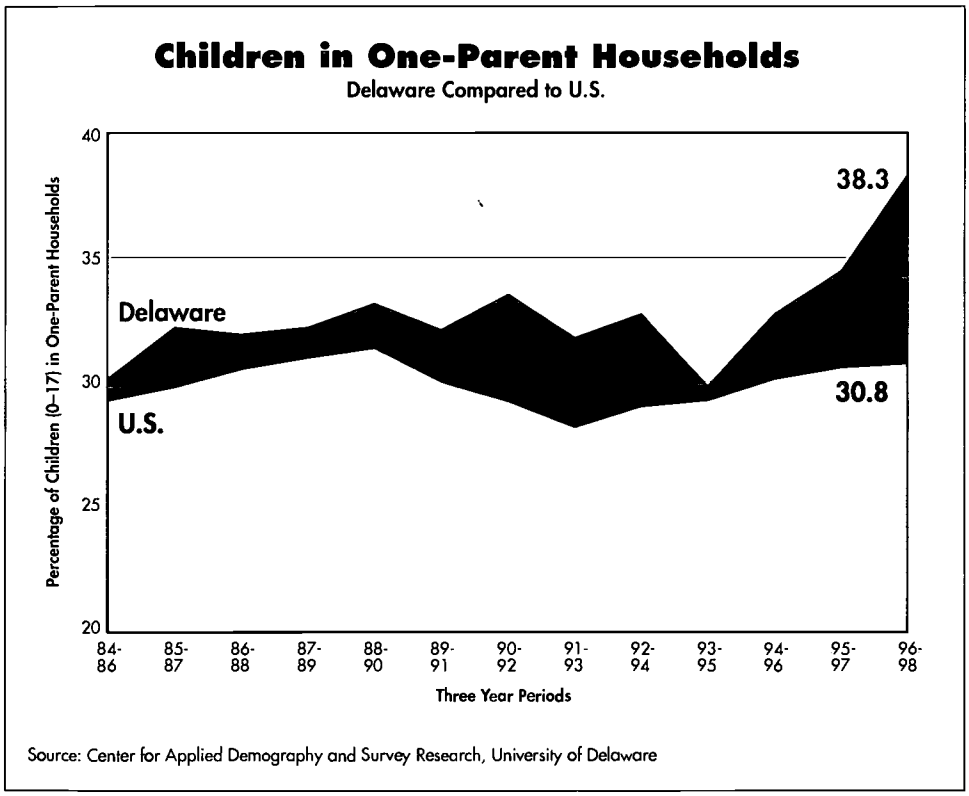
Indicator: Percent of children ages 0–17 in one-parent households

Children who live with one parent are much more likely to be living in poverty than children who live with two parents[1]. The risk is increased when the single parent is female due to the wage gap because of the type of job a woman is likely to have[2]. Delaware women, like their national counterparts, occupy a higher proportion of lower-paying occupations (such as sales, clerical, and service positions) than do men[3]. Census Bureau data reveal that in 1996, almost half (49%) of all children in families headed by single mothers were below the poverty threshold[1].

1 Children's Defense Fund. (1998). *The State of America's Children Yearbook 1998.* Washington D. C.

2 Ellwood, D. T. (1988). *Poor Support: Poverty in the American Family.* New York: Basic Books.

3 Office of Occupational and Labor Market Information: Delaware Occupational Information Coordinating Committee. (1997). *Delaware Women: Where are they Working?*



Source: Center for Applied Demography and Survey Research, University of Delaware

For more information see

Female Headed Households in Poverty	p. F-38
Child Support	p. F-39
In the KIDS COUNT Section:	
Birth to Unmarried Teens	p. K-19
Infant Mortality by Martial Status of Mother	p. K-23
Children in Poverty by Household Structure	p. K-35
Children in One-Parent Households	p. K-36
Table 7	p. K-56
Table 20	p. K-65
Tables 47-62	p. K-78-84

Teen Births

Indicator: Teen birth rate per 1,000 females age 15–17

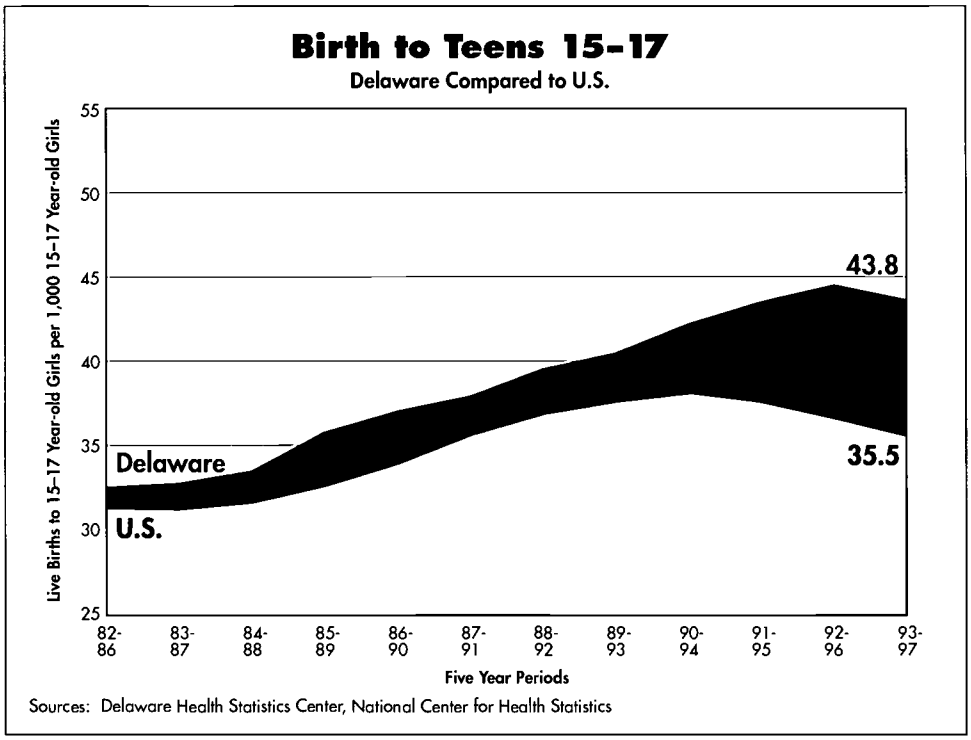
When an adolescent becomes a mother, the teen, her baby, and society all have to deal with the consequences. These consequences are often attributable to poverty and other adverse socioeconomic circumstances that frequently accompany early childbearing[1]. Teen mothers tend to be disadvantaged at the time of their child's birth. With the new demands of parenting, they are at risk of falling even further behind their more advantaged counterparts who will not become pregnant as teens. Teen mothers are more likely than other mothers to need additional financial support and to obtain less education[2].

Babies born to teens generally have a greater risk of health problems than those born to older women. Problems tend to follow these children throughout life. In preschool, they display higher levels of aggression and lower levels of impulse control. By adolescence, these children tend to have higher rates of grade failure and more delinquency. They become sexually active at an early age and are likely to become parents as teens themselves[3].

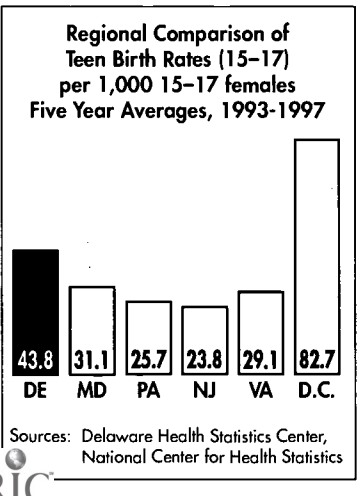
1 Males, M. (1997). Women's health: adolescents. *Lancet, 349* (Supplement I), 13-16. Bacharach, C. A. and Carve, K. (1992). Outcomes of early childbearing: an appraisal of recent evidence. Summary of the National Institute of Child Health and Human Development conference, Betheseda, MD.

2 The Alan Guttmacher Institute. (1994). *Sex and America's Teenagers*. New York and Washington.

3 Children's Defense Fund. (1998). *The State of America's Children Yearbook 1998*. Washington D. C.



Sources: Delaware Health Statistics Center, National Center for Health Statistics



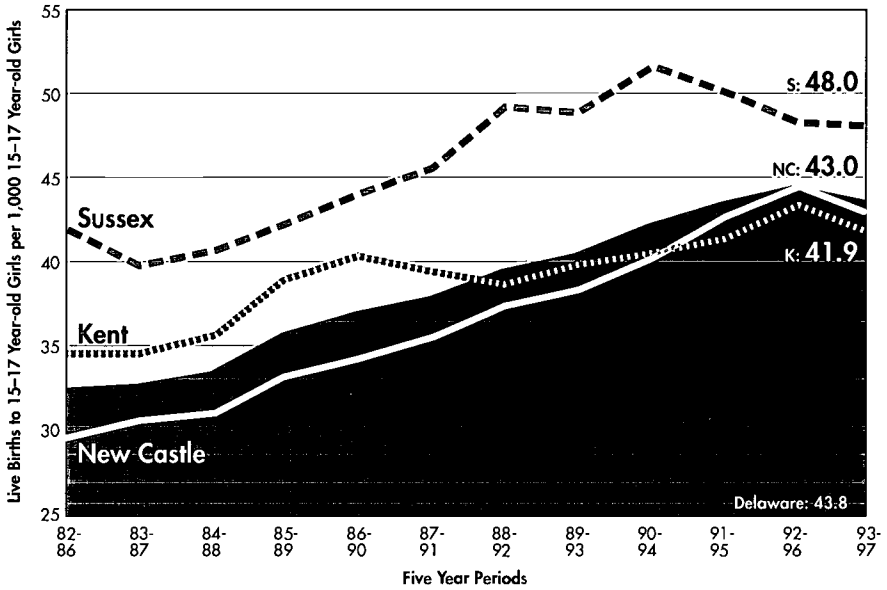
Sources: Delaware Health Statistics Center, National Center for Health Statistics

Program Statement: In Delaware, becoming a teen parent doesn't pay. Mothers under 18 who gave birth after January 1, 1999 receive no cash benefits for the baby, but instead receive other forms of short term assistance.

Through the Teen Hope Initiative, Delaware provides one-on-one and group counseling in 6 School Based Health Centers and four community programs. At-risk teens are identified through negative pregnancy tests, positive STDs, history of substance abuse, and other risk factors. Plans are also underway to create a fully coordinated youth program at a Wilmington community center by adding academic and entrepreneurial development components to the intensive counseling program. The goal is to improve educational and economic opportunities while decreasing at-risk behaviors. The expectation is that providing teens with opportunities will encourage them to delay pregnancy.

Birth to Teens 15-17

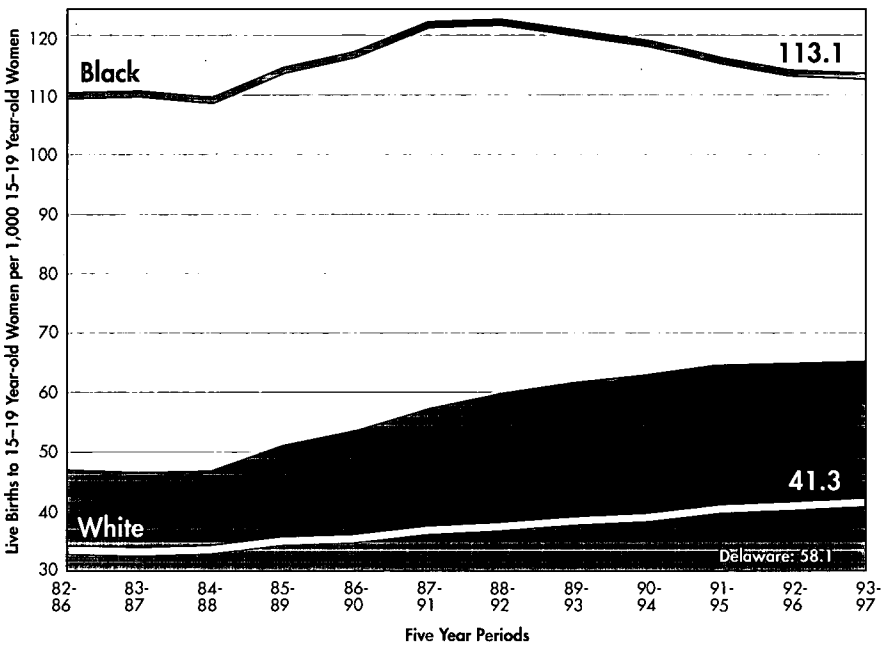
Delaware and Counties



Sources: Delaware Health Statistics Center

Births to Teens 15-19*

Delaware by Race



* 15–17 year old population data by race is currently unavailable

Sources: Delaware Health Statistics Center

For more information see

Female-Headed Households in Poverty

Indicator: Percent of families in poverty with female single head of household and children under 18

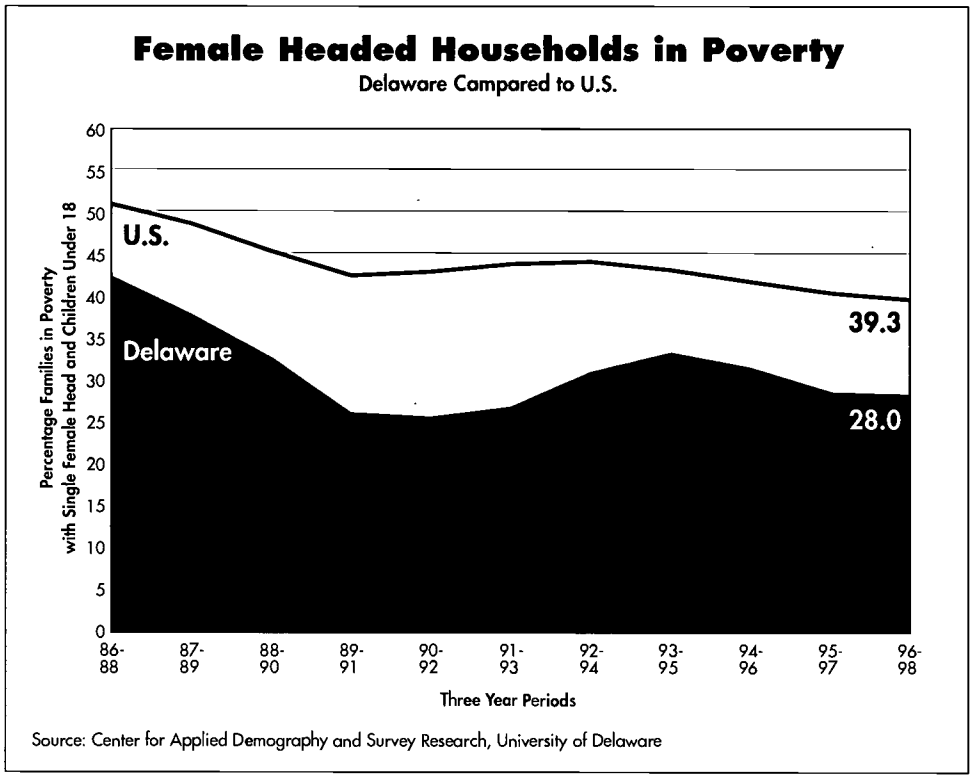
In a 1999 study conducted by The Center on Budget and Policy Priorities, it was found that between 1995 and 1997 the income of the poorest 20 percent of female-headed families with children fell an average of $580 per family. The study included the families' use of food stamps, housing subsidies, the Earned Income Tax Credit, and other benefits. Even when these benefits are included, these families have incomes below three-quarters of the poverty line.[1]

Additionally, studies have found that single mothers on welfare rarely find full-time, permanent jobs at adequate wages.[2] *Recent welfare legislation has focused on child support enforcement. However, full payment of child support only constitutes a small portion of the total cost of raising a child.*[3]

1 Center on Budget and Policy Priorities. (1999). *The Initial Impacts of Welfare Reform on the Incomes of Single-Mother Families.*

2 Hardina, D. (1999, Summer). Employment and the use of welfare among male and female heads of AFDC households. *Affilia Journal of Women and Social Work.*

3 Lino, M. (1998, Winter). Do child support awards cover the cost of raising children? *Family Economics and Nutrition Review.*



Source: Center for Applied Demography and Survey Research, University of Delaware

Program Statement: Although Delaware's child poverty rate is one of the lowest in the country, we strive to eliminate poverty for families, especially those with single parents. Through programs that enforce child support payments, offer subsidized childcare and other employment supports, and discourage teen pregnancy, we hope to provide a stable environment for children to thrive.

For more information see

One Parent Households	p. F-35
Child Support	p. F-39
In the KIDS COUNT Section:	
Children in Poverty by Households Structure	p. K-35
Children in One-Parent Households	p. K-36
Table 7	p. K-56
Table 47	p. K-78
Tables 55-60	p. K-81-83

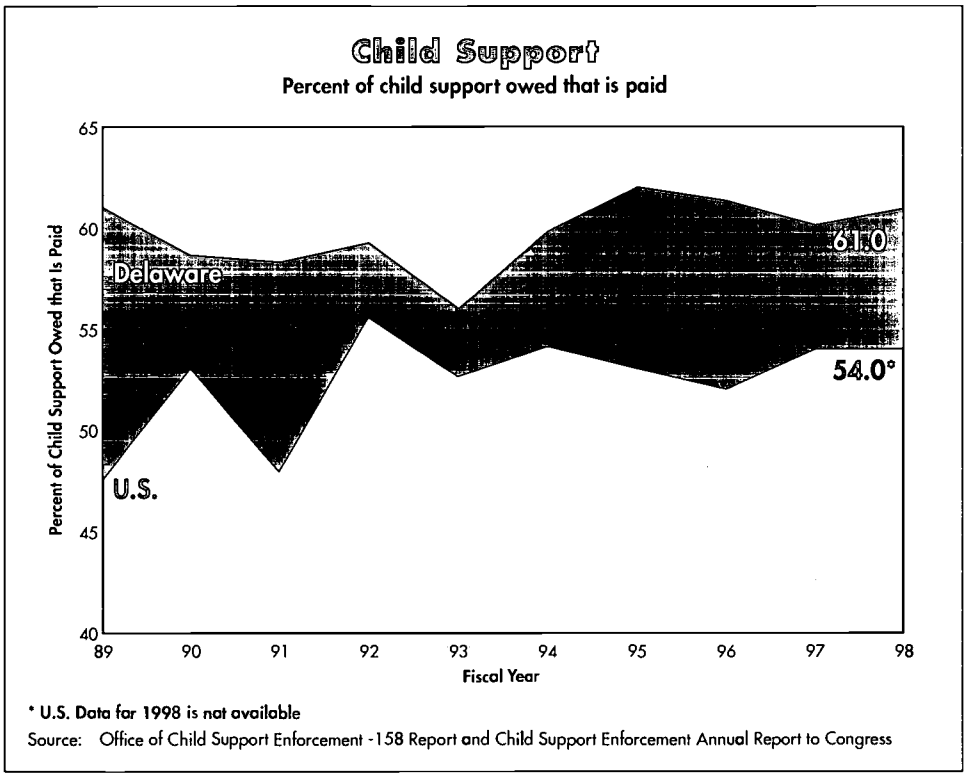
Child Support

Indicator: Percent of child support that is paid

The ability to meet the needs of children is, in many cases, out of the control of the parent who lives with and cares for those children. Many social and economic factors necessitate the need for services such as child support enforcement in order for some parents to fulfill their responsibilities to their families[1]. The failure of an absent parent to pay child support has significant consequences for a parent raising a child/children alone. Even when there is a child support agreement in place, child support payments tend to be low and unreliable[2].

1 Maine KIDS COUNT. (1997). Social and economic opportunity. *Maine KIDS COUNT 1997 Data Book.*

2 Rhode Island Department of Administration, Division of Taxation, Child Support Enforcement. (1996, December). As cited in *1997 Rhode Island KIDS COUNT Factbook.*



* U.S. Data for 1998 is not available

Source: Office of Child Support Enforcement -158 Report and Child Support Enforcement Annual Report to Congress

Program Statement: In Delaware, the financial responsibility for children belongs to both parents. The Division of Child Support Enforcement helps parents collect money from absent parents to raise a child. The Division assists in establishing paternity and support orders and enforces collections through wage withholding and other means.

For more information see
In the KIDS COUNT Section:
Table 59 p. K-82

Risk of Homelessness

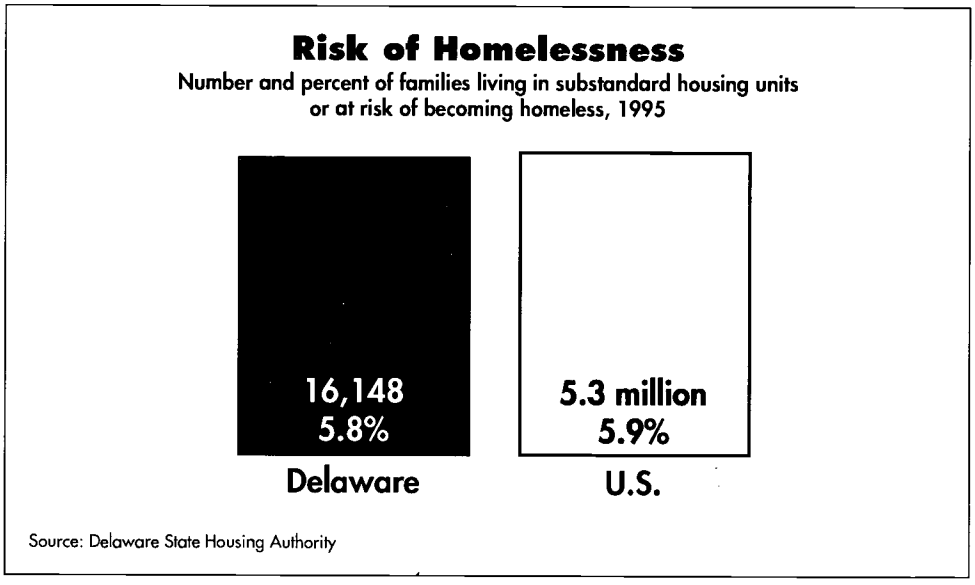
Indicator: Percent of families at risk of becoming homeless or living in substandard housing units

Homelessness is a devastating experience for families. It disrupts virtually every aspect of family life, damaging the physical and emotional health of family members, interfering with children's education and development, and frequently resulting in the separation of family members.[1] Most of the homeless are victims. Some have suffered from child abuse, violence, or are emotionally disturbed.

One out of four homeless people is a child. The fastest growing homeless group in the United States is families with children. However, many of the homeless children are alone. They may be runaways who left home because there is no money for food, because they are victims of rape, incest, or violence, or because both or one of their parents is in emotional turmoil.[2]

1 National Coalition for the Homeless. (1999, June). *Homeless Families with Children: Fact Sheet*. N7.

2 Kroloff, Charles A. (1993). 54 Ways You Can Help The Homeless: Overview. Hugh Lauter Associates, Inc. and Behrman House, Inc. NJ and CT.



Program Statement: Delaware knows that families need more than just a temporary roof over their heads when they are facing homelessness. They need security along with hand-in-hand assistance in picking up the pieces that stabilize their lives and help them get back on the road to independence. Where possible, Delaware State Housing Authority makes every attempt to rescue not just the family, but also the substandard homes, by providing funds that repair the health and safety hazards pushing families toward homelessness. For families on the verge of homelessness due to a crisis causing them to fall behind on their housing costs, we provide emergency funds. Because the threat is imminent for many of these families, Delaware State Housing Authority bridges the gap between that state's network of homeless providers to jointly create one seamless, holistic continuum of care on which homeless families can rely to take care of their immediate needs, while helping them rebuild their lives. By pooling resources, and preventing or solving the problems behind homelessness, Delaware makes full recovery realistic for families facing the scariest of times.

For more information see

Substandard Housing p. F-56

Home Ownership p. F-57

...e KIDS COUNT Section:

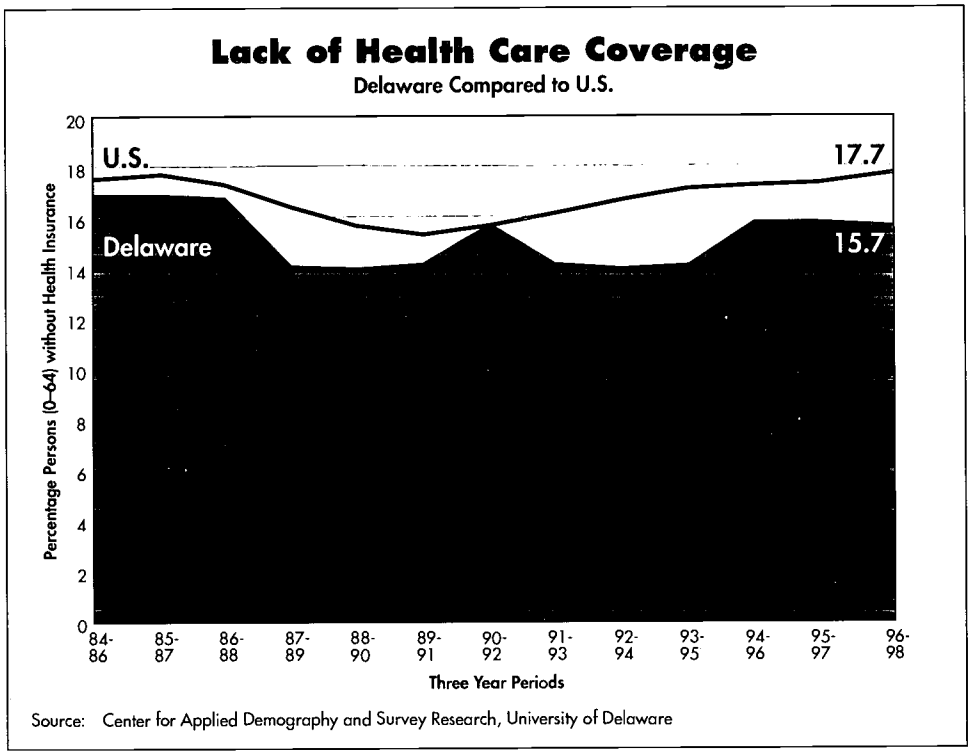
...e 54 p. K-81

Indicator: Percent of persons under age 65 who do not have health care coverage

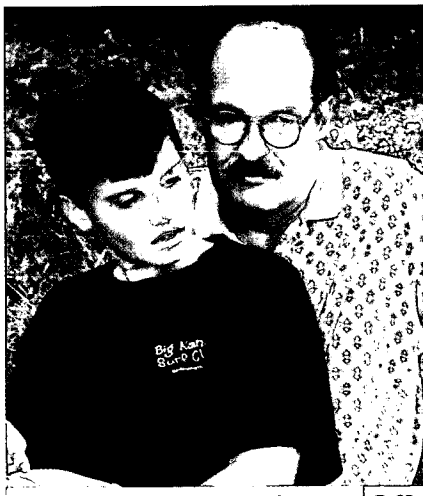
Presently, the U.S. is the only major industrialized nation that does not ensure universal access to health care for all of its citizens. Although the U.S. spends one out of every eight dollars on health care, over one-eighth of all Americans lack health insurance coverage. Another concern is health care cost inflation[1]. It is unlikely that the federal government will impose cost-containment provisions on the total amount spent for health care by this country as a whole or on that expended by the private health care sector. Thus, employers and individuals in the private sector experiencing problems due to the growth of their health care costs can expect little help from Congress[2].

1 Wong, J. D. (1997, June). Health care finance in the US: past, present, and future. *International Journal of Public Administration*, 20 (6), 1297-1315.

2 Blendon, R. J., Brodie, M., and Benson, J. (1995, January). What should be done now that health system reform is dead? *The Journal of the American Medical Association, 273* (3), 243-244.



Source: Center for Applied Demography and Survey Research, University of Delaware



Program Statement: In Delaware all citizens living below the poverty level have access to health insurance. The Diamond State Health Plan insures low-income adults and children, giving them access to needed medical prevention and treatment services. The Delaware Healthy Children Program provides low-cost coverage to children in families with income up to twice the poverty level, extending coverage to more children of the working poor. With these programs and private health insurance, 89% of Delaware's under 65 population has access to medical insurance.

For more information see

Health Care Coverage (Children)	p. F-19
In the KIDS COUNT Section:	
Asthma	p. K-43
Children without Health Insurance	p. K-44
Table 51-52	p. K-80

Nurturing Families

Goal: Families will provide a nurturing environment for all members free of violence, neglect, and abuse.

Child Abuse

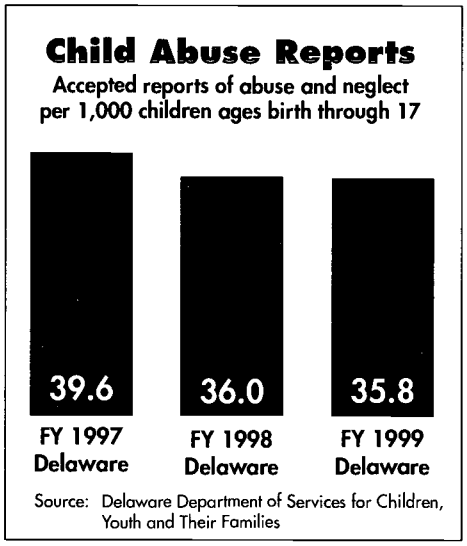
Indicator: Children with substantiated reports of abuse or neglect per 1,000 children ages birth through 17

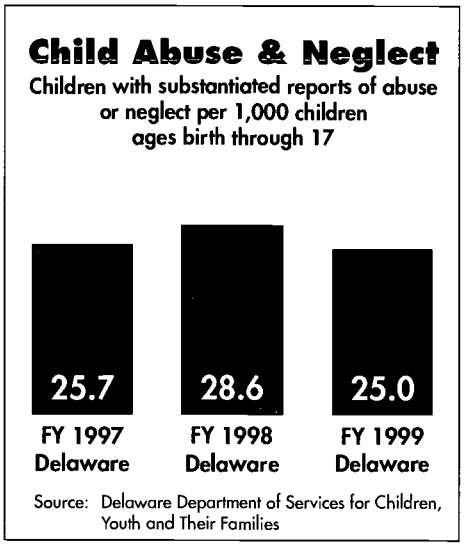
Accepted reports of abuse and neglect per 1,000 children ages birth through 17

Every year, nearly three million children throughout the United States are reported to child protective services agencies as alleged victims of child maltreatment. Of these, more than one million children are confirmed to be victims of abuse or neglect[1]. The consequences of child abuse and neglect are overwhelming. Child maltreatment can result in death, permanent disability, delayed development, mental and behavioral problems, teen pregnancy, criminal behavior, depression, and suicide[2].

1 U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. (1996). *Child Maltreatment 1994: Reports from the States to the National Center on Child Abuse and Neglect.* Washington, D. C.

2 Georgians for Children. (1996). *1996-97 Georgia KIDS COUNT Factbook.*





Program Statement: The state has several programs to intervene early to help prevent child behavior or family problems from escalating to the point where abuse or neglect would become more probable.

K-3 Early Intervention Program – This early intervention program is for children in kindergarten through third grades who are having behavioral or family problems that are interfering with their success in school. School-based Family Crisis Therapists work with the children and their families through one-on-one and group counseling, parent training programs, and other services to address and resolve the sources of the behavior or family issues.

Families and Schools Together (FAST) – This prevention program aims at reducing the risks of school failure, juvenile delinquency, and substance abuse in adolescents for children in grade schools and their families. The program includes parent education and family activity components aimed at enhancing family functioning and decreasing problematic child behaviors.

(Continued on next page)

For more information see

Child Deaths	p. F-18
Children in Out-of-Home Care	p. F-45

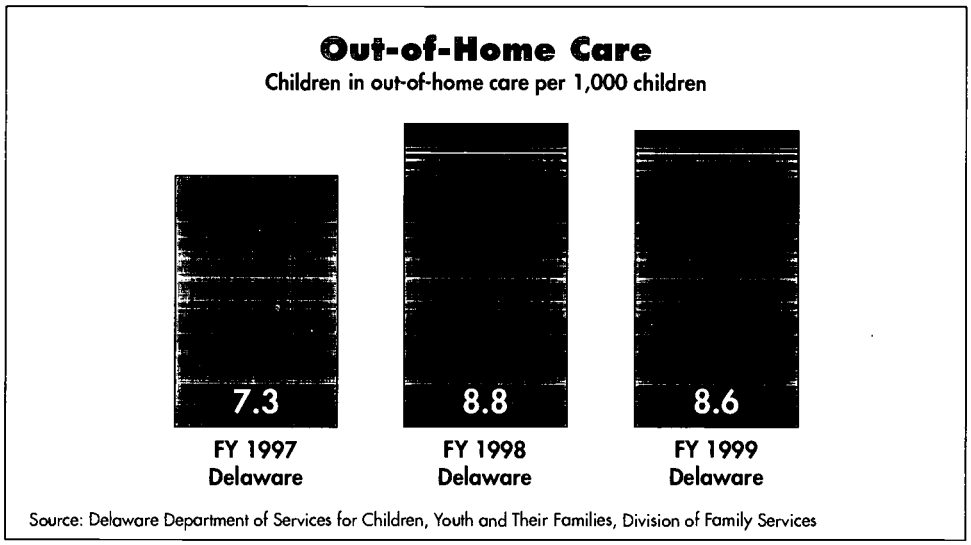
In the KIDS COUNT Section:

Child Deaths	p. K-24
Child Abuse	p. K-48
Figures 22-23	p. K-66-67
Table 66	p. K-86

Indicator: Children in out-of-home care per 1,000 children

Out-of-home placements include non-relative foster homes, relative foster homes, specialized foster homes, group homes, shelter care, residential treatment centers, and medical facilities. The most frequent reasons children are removed from their homes are neglect, lack of supervision, sexual or physical abuse, and incapacity of the parent. Increasingly, parental abuse of alcohol and illegal drugs are contributing factors leading up to the need for substitute care. Some children are in out-of-home placements because they represent a danger to themselves, their families, or their communities[1].

1 U.S. General Accounting Office. (1995). *Child Welfare: Complex Needs Strain Capacity to Provide Services.* Washington, D. C.



Program Statement: *(Continued from previous page)*

Families and Centers Empowered Together (FACET) – FACET is a prevention program for parents of pre-schoolers in licensed child care centers in neighborhoods with high rates of teenage parenthood, substance abuse, economic disadvantage, stress and crime. Parents participate in alcohol/drug awareness activities, parent education/support groups, life skills, health and education workshops, and family activities.

Promoting Safe and Stable Families – This program is aimed at strengthening community services infrastructure by providing family preservation and support services at seven community and school-based sites across the state. Family Resource Coordinators at each site assist families with service referrals, parent education, child care and recreational programs, and job search assistance.

For more information see

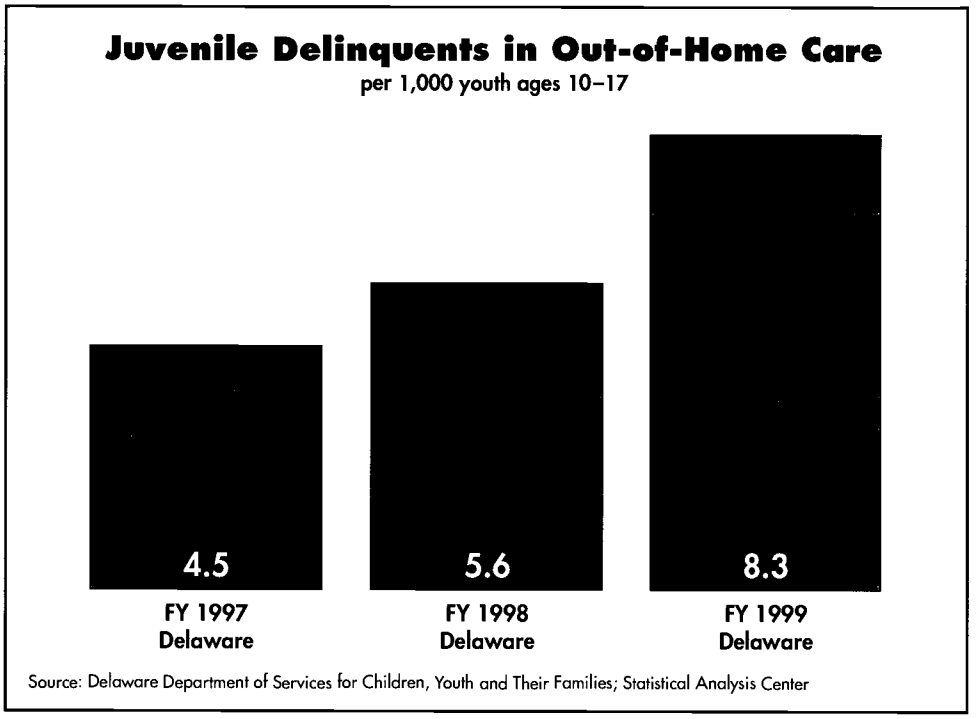
Child Abuse	p. F-44
Juvenile Delinquents in Out-of-Home Care	p. F-46
In the KIDS COUNT Section:	
Child Abuse and Neglect	p. K-48
Table 66	p. K-86

Juvenile Delinquents in Out-of-Home Care

Indicator: Juvenile delinquents in out-of-home care per 1,000 youth ages 10 through 17

Risk factors for juvenile crime and delinquency include a lack of educational and job training opportunities, poverty, family violence, and inadequate supervision. Research consistently suggests that youth who become involved in juvenile crime frequently have mental health problems prior to being incarcerated and incarcerated youth demonstrate significantly higher levels of psychopathology than non-incarcerated youth[1].

1 The David and Lucile Packard Foundation. (1996). *The Future of Children: The Juvenile Court.* Center for the Future of Children.



Source: Delaware Department of Services for Children, Youth and Their Families; Statistical Analysis Center

Program Statement: Some examples of programs used by the state to prevent continuing delinquency by youth on probation or community supervision in lieu of or on return to the community from an out-of-home placement are:

Project Stay Free – The Kingswood Community Center Project Stay Free is an intensive supervision program for youth on probation at high risk of re-offending. The program provides 24-hour, 7-day per week monitoring for 48 youth with electric monitoring for up to 10 youth.

Back on Track – This contracted prevention program through the YMCA Resource Center is for probation youth at low risk of re-offending and consists of five educational program components and supervised community service projects.

Multi-Systematic Therapy Program (MST) – This intensive home-based intervention program focuses on a youth's family, peer, and school relationships to reduce the environmental risks for juveniles at high risk of re-offending.

For more information see

Out-of-Home Care p. F-45
Juvenile Violent Crime p. F-53

In the KIDS COUNT Section:

ənile Violent
ne Arrests p. K-28
e 26-30 p. K-69-70

Indicator: Number of domestic violence reports

Domestic violence strikes people of all cultures, races, occupations, income levels, and ages[1]. It harms children's functioning and well-being in both the short- and long-term[2]. While some parents endure a beating in order to keep the batterer from attacking the children, studies show that in 50-70% of cases in which a parent abuses another parent, the children are also physically abused[3]. Additionally, children suffer emotional, cognitive, behavioral, and developmental impairments as a result of witnessing domestic violence in the home[4]. In particular, some children (especially boys) who experience domestic violence in their homes grow up to repeat the same behavioral patterns[5].

1 *New Castle County Police Domestic Violence Unit* at http://www.nccpd.com

2 Stephens, D. L. (1999, July). Battered women's views of their children. *Journal of Interpersonal Violence* (14), i7. p731.

3 Bowker, L.H. et al. (1998). On the relationship between wife beating and child abuse. *Feminist Perspectives on Wife Abuse*. pp.158-159, 162.

4 Jaffe, P. (1990). *Children of Battered Women*. 28.

5 Hotaling, G. T. and Sugarman, D. B. (1986). An analysis of risk markers in husband to wife violence: the current state of knowledge. *Violence and Victims*. pp. 101, 106.

Domestic Incident Reports

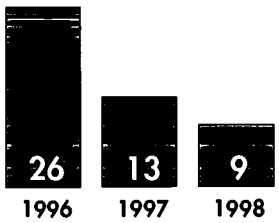
Delaware, 1998

Criminal Only	16,030 reports
Combined Criminal and Non-criminal	26,884 reports
Percent of Reports with a Child Present	36.6%
Percent of Reports with an Active Protection from Abuse Court Order	4%

Source: Dept. of Public Safety, Division of State Police

Deaths as a Result of Domestic Violence

Delaware, 1996–1998



Of the persons who died in this period **64%** died as the result of the use of a firearm.

Source: Dept. of Public Safety, Division of State Police

Program Statement: Domestic violence is a pattern of controlling and assaultive behavior that occurs within the context of adult, familial or intimate relationships. There are five central characteristics of domestic violence:

1. It is a learned behavior
2. It typically involves repetitive behavior encompassing different types of abuse such as coercion and threats, intimidation, emotional abuse, isolating the victim, minimizing, denying and blaming, economic abuse and using children.
3. The batterer, not substance abuse, the victim, or the relationship, causes domestic violence.
4. Danger to the victim and children is likely to increase at the time of separation
5. The victim's behavior is often a way of ensuring survival

There is cycle of domestic violence that begins with increased tension and anger, a battering incident in which the victim is slapped, kicked, choked, or assaulted with a weapon, sexually abused, or verbally threatened or abused. This is followed by a calm state during which the perpetrator may deny the violence and promise that it will never happen again. Unless professional assistance is sought, the process will repeat itself in most cases and in general, intensifies.

For the first time, Delaware in 1998 compiled statewide statistics on the incidents of domestic violence. This report includes much information, which will be an invaluable baseline as we move into the next millennium and continue our efforts to reduce the incidents of domestic violence. Family Court tracks the number and disposition of Protection from Abuse orders that are filed in court which also tell a story.

Domestic Violence – The defendant or victim in a family violence case may be male or female, child or adult, or may be of the same sex. Family violence is any criminal offense or violation involving the threat of physical injury or harm; act of physical injury; homicide; sexual contact, penetration or intercourse; property damage; intimidation; endangerment, and unlawful restraint.

Child Present – A child is present at the time of the incident, as reported by the police.

Active PFA Order – Incidents in which there are any active court orders such as Custody, Protection from Abuse orders, No Contact orders, or other court orders.

Strong & Supportive Communities

Goal: Communities have child care, educational systems, social service systems, physical infrastructure, and employment opportunities to support a high quality of life for all community members. Communities are drug, crime, and violence free. Residents are actively involved in achieving community self-sufficiency.

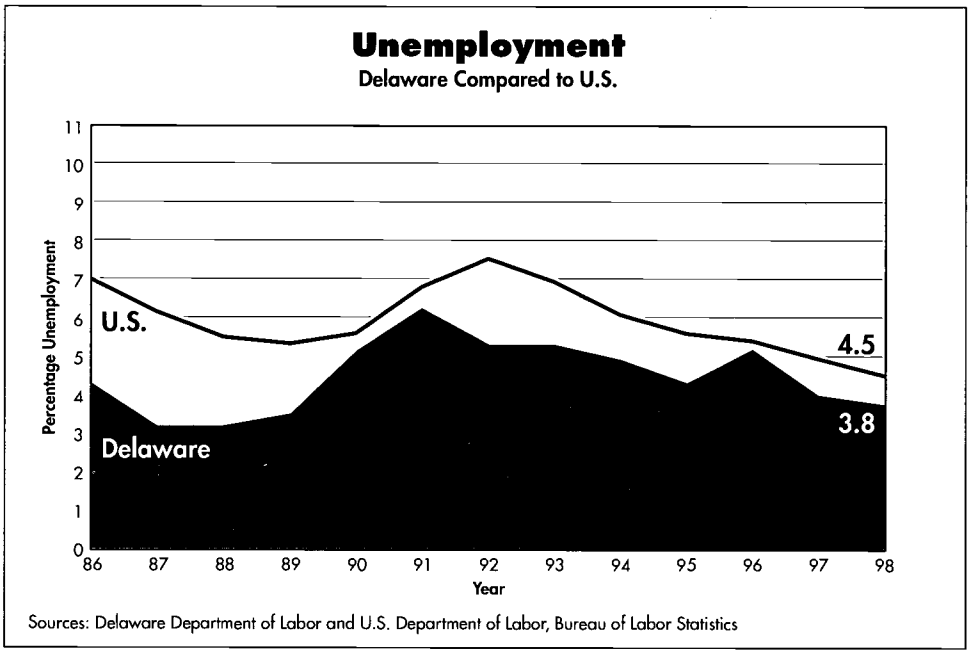
Unemployment

Indicator: Unemployment rates by race and gender

According to the U.S. Bureau of Labor Statistics, the unemployment rate is the lowest it has been since 1973. Suggestions as to why America has been successful in reducing unemployment include: excellent management by the Federal Reserve Board which has kept interest rates down without an increase in inflation, the deregulation of industries, and the opening up of global markets[1]. The rate does vary regionally. This dispersion is said to be due to several factors including crime, education, amenities, residency patterns, home ownership, international migration, and industry composition[2].

1 Glassman, J. K. (1997, December). Lonely unemployment line. *U.S. News & World Report, 123* (24), 36.

2 Partridge, M. D. and Rickman, D. S. (1997, August). The dispersion of U.S. state unemployment rates: the role of market and non-market equilibrium factors. *Regional Studies, 31* (6), 593-606.



Sources: Delaware Department of Labor and U.S. Department of Labor, Bureau of Labor Statistics

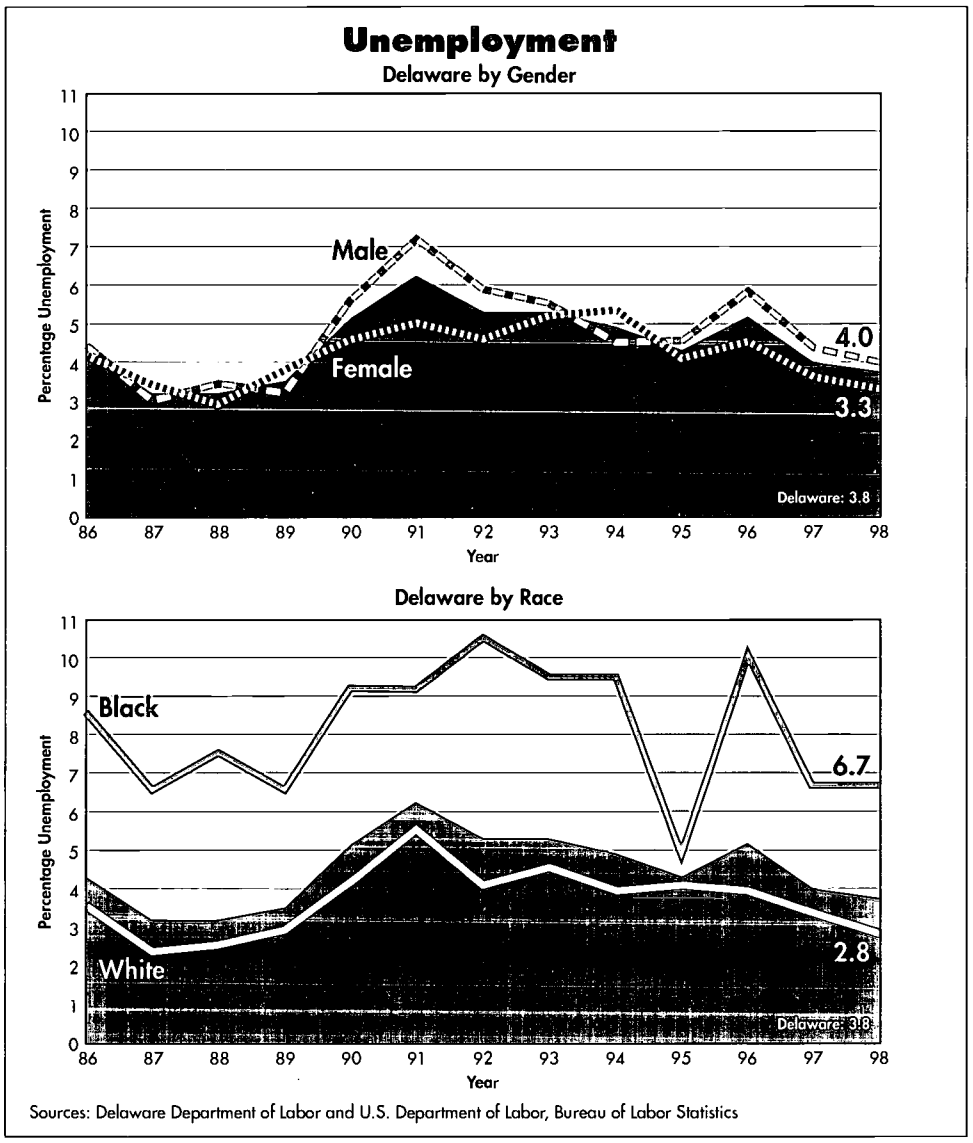
Program Statement: The Department of Labor is involved in numerous initiatives to enable people to become employed. The Division of Employment and Training provides a wide variety of one-stop integrated employment and training services to over 44,000 people annually through occupational skills training programs, school-to-work training programs, summer youth employment, and training programs, re-employment services, employer services, automated self-service and by matching job seekers with employment.

The Virtual Career Network (VCNet), Delaware's automated Internet One-Stop system developed by the Division of Employment and Training and the Office of Occupational and Labor Market Information (OOLMI) offers employers and job seekers easy and open access to an electronic data base containing jobs from across the country, a talent bank of electronic resumes, and links to a wealth of related occupational, training, education, and supportive services information.

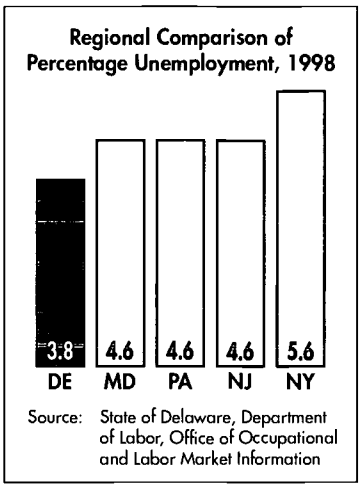
In September 1999, the Department of Labor launched Career Directions, an interactive Internet application to visually display key economic and demographic data such as employment training, licensed child care facilities and public transportation routes. It allows users to customize data in a variety of ways to determine what resources are conveniently located near home or work.

In conjunction with Department of Health and Social Services and the Delaware Economic Development Office, DET assists welfare recipients move from dependence to independence by obtaining and maintaining employment.

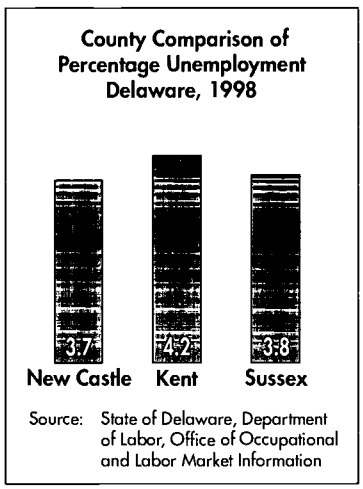
(Continued on next page)



Sources: Delaware Department of Labor and U.S. Department of Labor, Bureau of Labor Statistics



Source: State of Delaware, Department of Labor, Office of Occupational and Labor Market Information



Source: State of Delaware, Department of Labor, Office of Occupational and Labor Market Information

Program Statement: *(Continued from previous page)*

The mission of the Division of Vocational Rehabilitation is to provide opportunities and resources to eligible individuals with disabilities leading to success in employment and independent living. Approximately 720 people with disabilities will be successfully placed in jobs each year.

To respond to increasing needs of individuals with mental illness with their employment-related concerns, DVR initiated two new programs in 1998. Visions 2000 enables people with persistent mental illness to obtain and/or retain entry-level jobs by providing them with on-the-job supported employment assistance. The Pathways to Employment program provides mentoring to people who work at professional levels to assist them with career exploration and obtaining and keeping a job.

OOLMI produces several publications to assist people on preparing for careers. The new Stepping Stones labor market survival guide will help welfare clients acquire skills and attitudes necessary to survive in the labor market. The Delaware Career Compass has provided almost a decade worth of students and job seekers with critical information about job seeking skills, labor market information, and educational options.

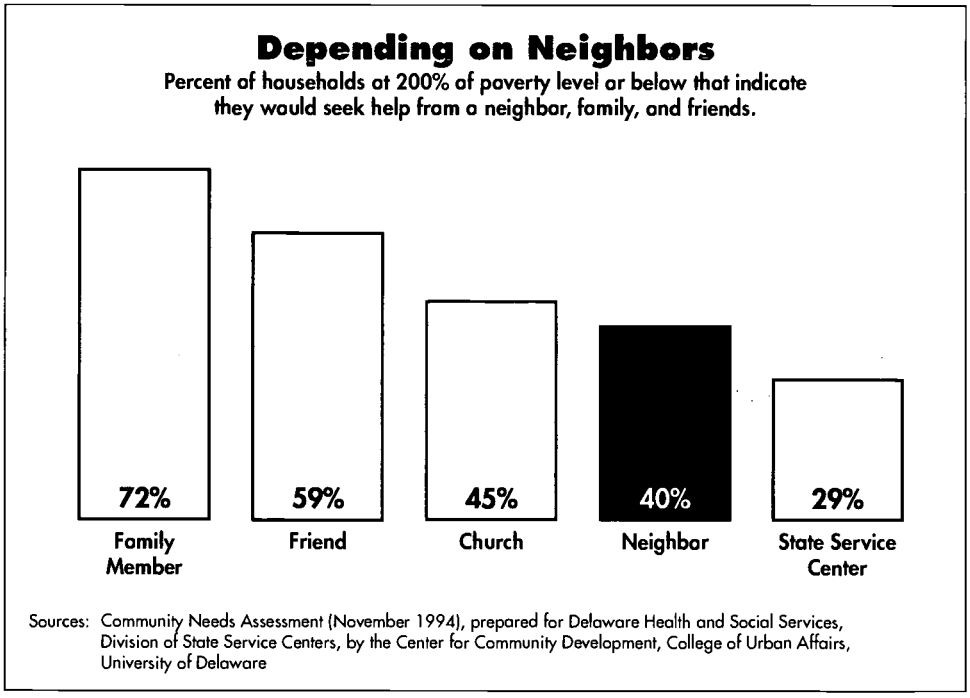
For more information see
In the KIDS COUNT Section:
Table 61 p. K-84

Depending on Neighbors

Indicator: Percent of households at 200% of poverty level or below that indicate they would seek help from a neighbor, family, and friends.

People sometimes experience alienation within their neighborhoods. It is important for community members to develop social relationships in order to share resources, services, and information[1]. When households are 200% poverty or below, they are at greater risk for alienation and may not have access to many resources or information. When a household would seek help from a neighbor, it is an indication that the community is strong and supportive of its members.

1 Egeberg, O. (1995, Fall). An exchange directory for every neighborhood. *Whole Earth Review, 86* p. 26-27.



Program Statement: In supportive communities, residents feel they can turn to neighbors for help. In high-risk areas, the need for easily-obtainable information is particularly important since residents may find it difficult to access the system. Since 1995, several initiatives have been implemented to empower high-risk communities and disseminate information to them. For example, Family Services Partnerships have been established in eight high risk areas. Training, technology, and technical assistance have been provided regularly to the Partnerships to help them support their communities.

Juvenile Violent Crime

Indicator: Juvenile violent crime arrest rate

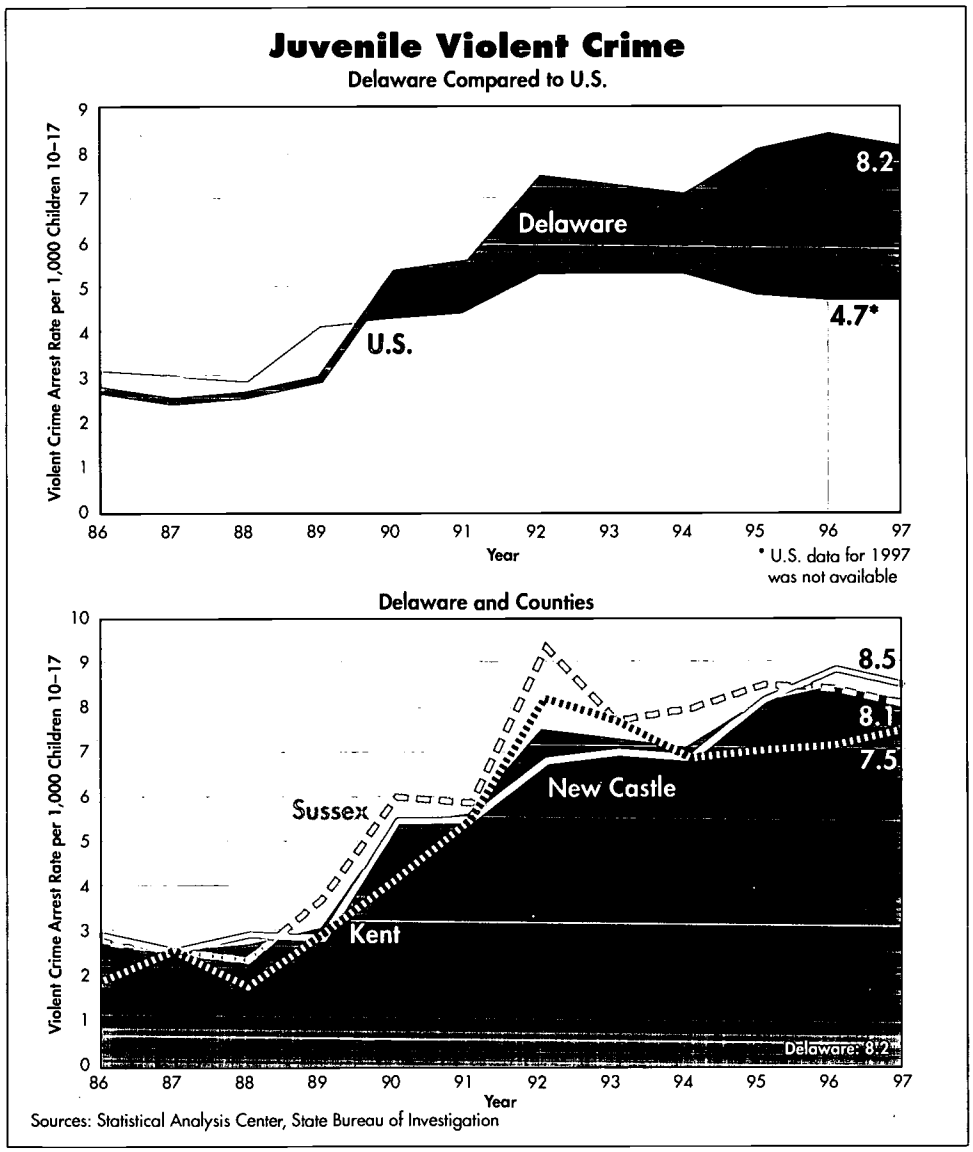
Risk factors for juvenile violent crime and delinquency include poor school performance and limited job opportunities[1]. Poverty, family violence, and inadequate supervision are also factors that increase risk[2]. The general public adds media's influence to this list citing: too much sex and violence in the movies, too much sex and violence on TV, too much emphasis on sex in advertising, and rock music lyrics that glorify sex and violence [3].

Youth ages 12–19 are much more likely to be involved in crime as victims than any other age group. Teens are the victims of three in ten violent crimes and one in four thefts. They are also the least likely group to report the crimes[3].

1 Delinquency. *Britannia Online.* Available <http://www.eb.com:180/cgi-bin/g?DocF=micro/164/30.html>.

2 Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. (1995). *Juvenile Offenders and Victims, A National Report.* Washington, D.C.

3 Indiana Youth Institute, KIDS COUNT in Indiana. (1994). *Kids, Crime, ad Court: The Juvenile Justice System in Indiana.*



Sources: Statistical Analysis Center, State Bureau of Investigation

Program Statement: The Delaware Prevention Network (DPN) is one of Delaware's prevention programs for juveniles. DPN employs program components that are focused on youth, family, and community support networks. Another program is the Stormin' Norman's Classic Basketball League. About 1,400 youth ages 9 to 18 play on 114 teams in Wilmington. In addition to the basketball games, the program has components that deal with education, health, public safety, and community volunteer work.

For more information see

Teen Deaths	p. F-23
Juvenile Delinquents in Out-of-Home Care	p. F-46
Adult Violent Crime	p. F-54
Adults on Probation or Parole	p. F-55

In the KIDS COUNT Section:

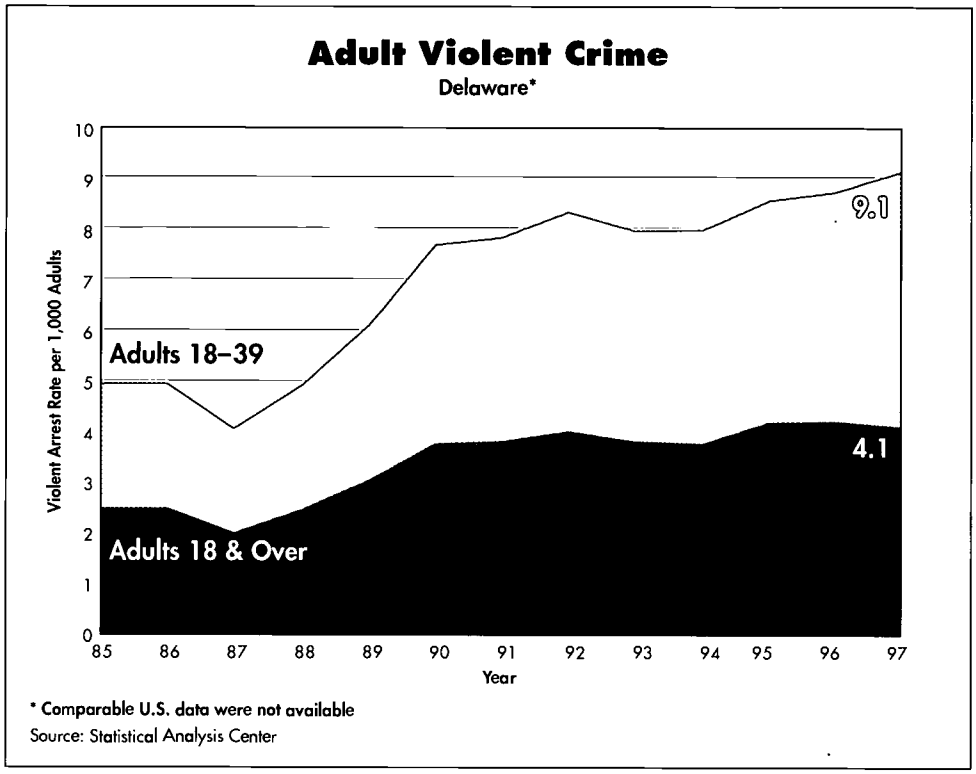
Juvenile Violent Crime Arrests	p. K-28
Teen Deaths	p. K-26
Table 24	p. K-68
Tables 26-38	p. K-69-74

Adult Violent Crime

Indicator: Adult violent crime arrest rate per 1,000

Among the steps being taken to combat crime is the dramatic increase in incarcerations. Additionally, tougher sentencing laws are ensuring that criminals across the nation are staying in jail for longer periods of time. However, imprisonment is costly business; increasingly, states will have to make tough spending decisions about whether to construct additional prisons or to invest in area schools, roads, tax cuts, etc. [1]

1 Fischer, K. (1998, January-February). Is locking them up the answer? For violent criminals probably—for the rest, it's not so clear. *Washington Monthly*, 30 (1), 32-34.



* Comparable U.S. data were not available

Source: Statistical Analysis Center

Program Statement: In order to meet the demands of an increasingly complex society, the Delaware State Police has aggressively pursued innovative programs to address violent crime. The use of the new DICAT (Division Wide Crime Analysis Tracking) system provides "real time" data to allow deployment of officers to address increases in criminal activity in specific geographic locations. The Community Services section addresses crime prevention issues that have an impact on the quality of life in Delaware's communities. Officers provide seminars on topics such as robbery and burglary prevention, neighborhood watch programs, safe traveling tips, self protection, and domestic violence. The Citizen's Police Academy provides participants a greater understanding of police practices, and the tools to form objective opinions regarding police action and to address community concerns regarding these actions. Participants are provided with knowledge that empowers them to participate in activities that reduce criminal activity in their communities.

For more information see

Juvenile Violent Crime p. F-53

Juvenile Delinquents in Out-of-Home Care p. F-46

Adults on Probation or Parole p. F-55

In the KIDS COUNT Section:

nile Violent
ne Arrests p. K-28

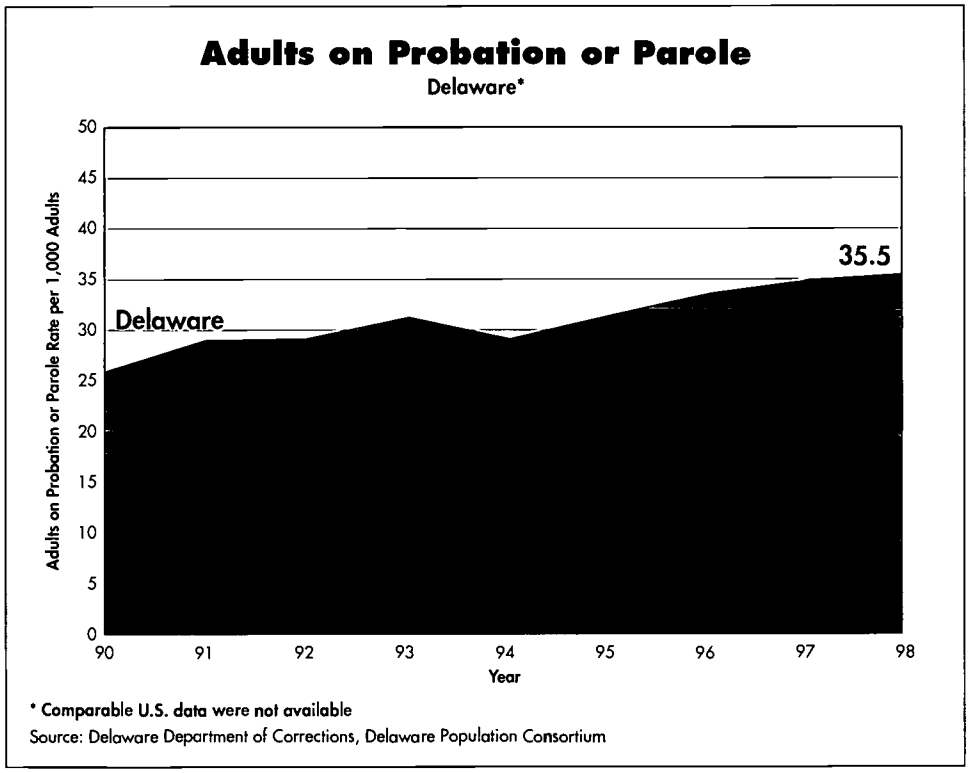
es 26-38 p. K-69-74

Adults on Probation or Parole

Indicator: Adults on probation or parole under supervision per 1,000 adults

Intermediate sanctions such as probation and parole are needed to help control inmate populations. Most probation or parole programs incorporate a wide variety of activities that emphasize close monitoring, participation in community service programs, tight curfews, steady employment, and drug testing[1].

1 Bennett, L. A. (1995, February). Current findings on intermediate sanctions and community corrections. *Corrections Today*, 57 (1), 86-89.



* Comparable U.S. data were not available

Source: Delaware Department of Corrections, Delaware Population Consortium

Program Statement: The Delaware Department of Correction is committed to public safety. The Bureau of Community Correction, Probation and Parole has teamed up with law enforcement agencies to increase community contacts and enhance visibility. The Safe Streets project initially focused on select neighborhoods within the city of Wilmington. In recent months, this initiative has expanded into New Castle County. In the coming year, efforts will be expanded statewide. Through Safe Streets we have identified those offenders in the community who are perhaps at higher risk for noncompliance with the conditions of supervision. The increased visibility and contacts in the community are impacting offender behavior and providing a greater sense of public safety in the community.

For more information see

Juvenile Violent Crime	p. F-53
Juvenile Delinquents in Out-of-Home Care	p. F-46
Adult Violent Crime	p. F-54

In the KIDS COUNT Section:

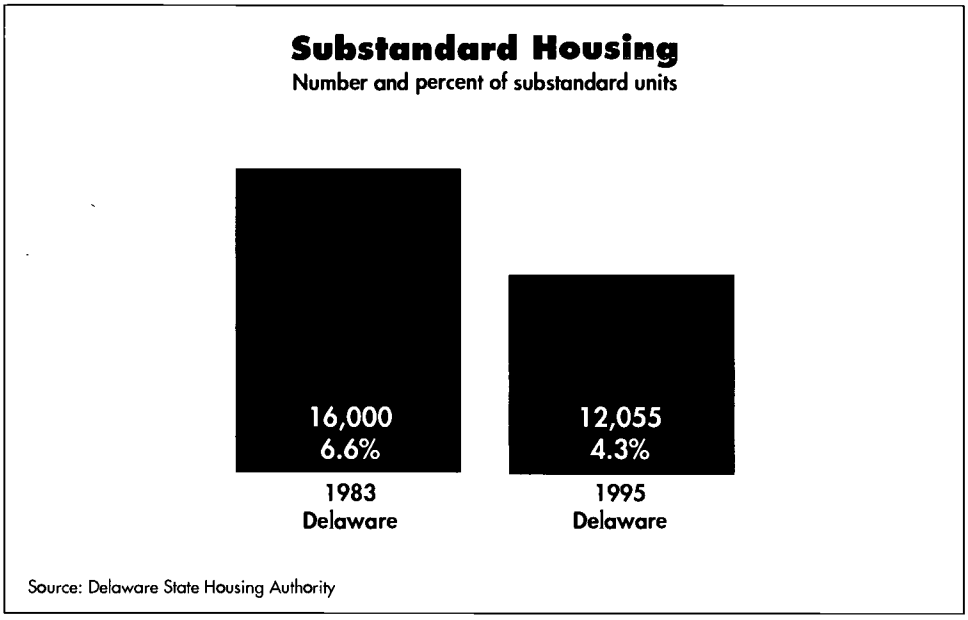
Juvenile Violent Crime Arrests	p. K-28
Tables 26-38	p. K-69-74

Substandard Housing

Indicator: Percent of substandard housing units

According to the Statewide Needs Assessment, more than 12,055 of Delaware's households are living in substantially substandard housing. This number reflects truly dilapidated living conditions as substantial rehabilitation is required in order to make these households structurally sound, safe, and habitable. Such rehabilitation is qualified as at least $30,000 per unit ($20,000 for a mobile home) in non-cosmetic repairs typically including at least two structural systems. It also includes units which may be otherwise structurally sound, but which have failing septic systems. At this time, there is no nationally comparable data available as Delaware's definition refers to a much more severe condition than national data.[1].

1 Delaware State Housing Authority (August 1996) *Statewide Housing Needs Assessment.* Prepared by Legg Mason Realty Group, Inc.



Program Statement: Realizing that substandard housing is more than a misfortune to the community—it is detrimental to the safety and overall well-being of "the family"—Delaware fights back against time's toll on our State's homes by rescuing financially-strapped families with low-interest rate, deferred loan packages, or grants in some cases, that enable the owners of these homes to make the necessary housing repairs. Just as each home is different and has different needs, so do families; therefore, we go one step further in repairing homes by making it affordable for families to modify homes for handicapped-accessibility when necessary. Also, grants are provided to communities to demolish vacant severely-substandard homes that might otherwise be environmentally and physically dangerous. Delaware State Housing Authority rounds out this rescue plan by empowering entire communities to repair infrastructure deteriorations, or in some cases build infrastructure they lack, to become safe for this generation, and the next.

For more information see

Risk of Homelessness p. F-40
Home Ownership p. F-57
...ie KIDS COUNT Section:
...e 54 p. K-81

Home Ownership

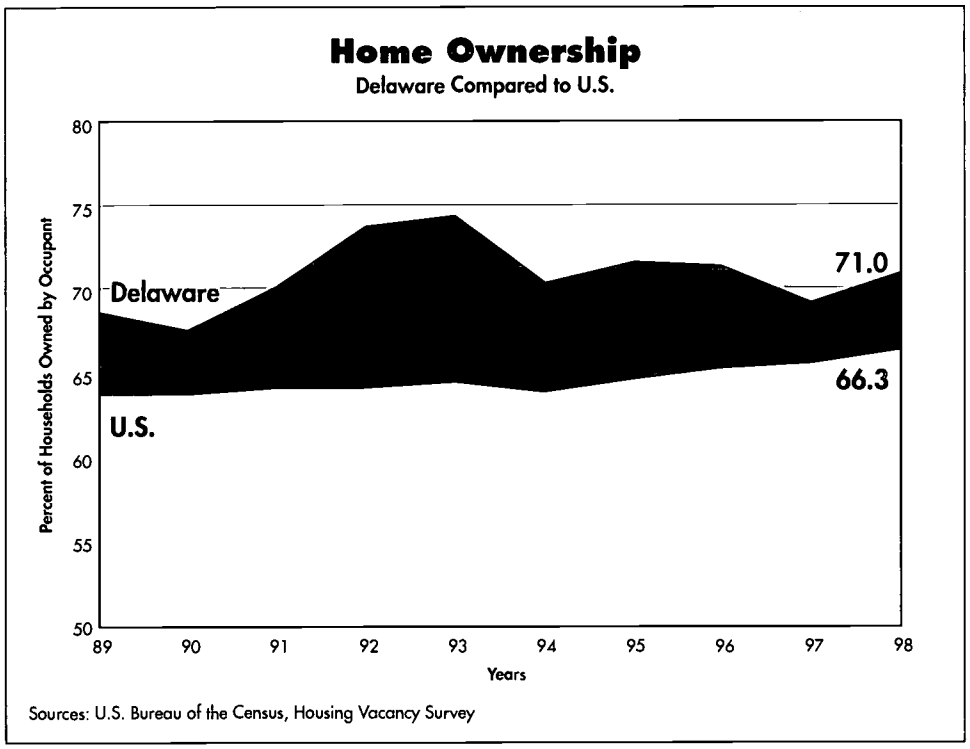
Indicator: Percent of home ownership

Nationally, 66.3 percent of Americans own the houses or apartments where they live[1]. This "American Dream" of homeownership has led the impetus for much public policy concerning housing and the lending markets used to finance home purchases[2]. Benefits of home ownership are many and varied. In addition to being an important savings vehicle for families, owning one's home is thought to create better citizens, enhance the stability of communities, increase the value of other property, and even improve the performance of children in school[3].

1 U.S. Bureau of the Census. 1998 Housing Vacancy Survey.

2 Longhofer, S.D., Peters, S. R. (1998, Winter). Beneath the rhetoric: Clarifying the debate on mortgage lending. *Economic Review*. 34 (4), 2.

3 Segal, L. M., Sullivan, D. G. (1998, March-April). Trends in homeownership: race, demographics, and income. *Economic Perspectives*. 22 (2), 53.



Sources: U.S. Bureau of the Census, Housing Vacancy Survey

FAMILIES COUNT in Delaware F-57

Program Statement: Delaware makes home ownership affordable to those who often think this American Dream is out of their reach. While working with many financial institutions, builders, and real estate companies across the state, Delaware State Housing Authority unlocks the doors to home ownership for low- and moderate-income families every day by providing low-interest rate mortgage financing, along with down payment and closing costs loans. DSHA also supports housing counseling, and offers education to rental communities—big and small—to help families map out their own realistic paths to home ownership. Furthermore, the sprouting-up of economically-integrated communities, and affordably-priced neighborhoods are important to the State as the DSHA focuses on making home ownership a more attainable goal for working families.

For more information see

Risk of Homelessness p. F-40

Substandard Housing p. F-56

In the KIDS COUNT Section:

Table 54 p. K-81

Indicators "Under Construction" and Where to Get More Information

The Family Services Cabinet Council has identified additional indicators which may further help to measure the well-being of Delaware's families. However, at the present time these indicators are still "under construction." Processes are being developed to collect the data that is needed. As soon as these data collections processes are completed, the results will be published in FAMILIES COUNT in Delaware.

- Percent of students going on to post-secondary enrollment
- School readiness measure

For more information about the programs described within FAMILIES COUNT in Delaware, contact the state agencies listed below:

Delaware Information Helplines
1-800-464-4357 (in state)
1-800-273-9500 (out of state)

State of Delaware Web Site
www.state.de.us

Office of the Governor,
Advisor on Family Policy
302-577-3210

Delaware State Housing Authority
302-739-4263

Department of Corrections
302-739-5601

Department of Education
302-739-4601
www.doe.state.de.us

Department of Labor
302-761-8000

Department of Health
and Social Services
www.state.de.us/dhss

- Division of Public Health
  302-739-4700
- Division of Social Services
  302-577-4400
- Division of Alcoholism, Drug
  Abuse and Mental Health
  302-577-4460

Department of Public Safety
302-739-4311

Department of Services for
Children, Youth and Their Families
302-633-2500
www.state.de.us/kids

Drug Free Delaware
www.state.de.us/drugfree

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

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